DOCTORAL THESIS

An exploration of how veterans diagnosed with combat-related post-traumatic stress disorder experience therapy

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Declaration of Interest

The author has no financial affiliations with Combat Stress.

Contents

1. Abstract

In 1980, the various symptoms of combat stress were formally classified as post-traumatic stress disorder (PTSD), now an established condition with supporting research on its prevalence, possible causes and treatment options. As a diagnosis, however, it is marked by persistent questions about its validity as a conceptualisation of this group of symptoms. This kind of questioning stance is characteristic of counselling psychology as a discipline, which attempts to straddle both the scientific and therapeutic worlds of psychology. This latter, more subjective and interpretative world is currently absent from PTSD research and there is a consequent lack of understanding as to the perspective of those who have a PTSD diagnosis and who have undergone treatment for it.

This research aims to fill this gap in the literature by asking veterans diagnosed with combat-related PTSD to describe and explore their experience of therapy. Six male participants were recruited on a voluntary basis from Combat Stress, the UK's leading charity specialising in the care of veterans' mental health. All participants served on a full time basis for the Armed Forces in a combat role and have since been diagnosed with combat-related PTSD by a Combat Stress psychiatrist. The data was collected using semi-structured interviews lasting around one hour. Analysis of the data was conducted using Interpretive Phenomenological Analysis (IPA), an inductive method which aims to explore and understand how a phenomenon is experienced from the perspective of those involved.

Two master themes emerged, 'being misunderstood' and 'developing understanding', each with three subthemes. These themes explore these participants' accounts of the internal confusion caused by PTSD symptoms and the external struggle to be understood by others and receive necessary help. These themes also engage with how the participants report a growing commitment to therapy, their developing relationships with themselves and their therapists, and the value of normative experiences in a safe environment.

Together these themes form an interpretative answer to the research question: how do veterans diagnosed with combat-related PTSD experience therapy? The themes are explored in depth and links are drawn between them and the wider literature. The implications of this for counselling psychology practice are discussed, and suggestions for further research are made.

2. Introduction

My father sat in his chair recovering
From the four-year mastication by gunfire and mud,
Body buffeted wordless, estranged by long soaking
In the colours of mutilation.
His outer perforations
Were valiantly healed, but he and the hearth-fire, its blood- flicker
On biscuit-bowl and piano and table-leg,
Moved into strong and stronger possession
Of minute after minute, as the clock's tiny cog
Laboured and on the thread of his listening
Dragged him bodily from under
The mortised four-year strata of dead Englishmen
He belonged with […]
His memory's buried, immovable anchor,
Among jawbones and blown-off boots, tree-stumps, shell-cases and craters, […]

This is an extract from *Out* by Ted Hughes (p. 448, 1996). It is written about his father, William, who was one of only seventeen survivors from his regiment after the First World War's Gallipoli campaign of 1915-16. William Hughes's experience is not unique. Soldiers in the US Civil War, the Boer War, the First and Second World Wars, the 1991 Gulf War and the most recent wars of Iraq and Afghanistan have all reported experiences and feelings which he might recognise, the 'strange hells within the minds war made' (Gurney, p. 447, 1996).

What medical and mental health professionals will also recognise is his son's efforts to describe and understand the experiences of his father. The struggle of a third party to adequately encapsulate the experience of another is repeated over and over in mental health literature and practice; how can we accurately describe and understand the nature, impact and effect of a mental health problem? Current understandings mean that today, William Hughes would probably be given a diagnosis of combat-related post-traumatic stress disorder (PTSD), but the debate continues as to whether this is sufficient. Does PTSD meaningfully capture the experience of the people who suffer from it or is it simply the best we can do, the closest we can get?

Today's prevailing empirical and positivist attitudes towards both physical and mental health mean that the existing research and literature on PTSD has been undertaken almost entirely from this philosophical stance, conducted 'scientifically', using objective statistical analysis and producing fact-based conclusions and diagnoses. This has left a gap in the research. We know almost nothing about the perspective of those who have been in combat, suffered as a consequence of it and been through the mental health system in order to get help. It is this perspective, the subjective, first-person perspective that starts with the individual and their context with which this research is concerned.

The aim of this research is to gain an understanding of the lived experience of its participants, six men who have seen active service in the UK Armed Forces and who have subsequently been diagnosed with combat related PTSD and in doing so, answer the research question how do veterans diagnosed with combat-related PTSD experience therapy?

Secondary to this is an exploration of how their experiences fit with the current understandings of this mental health problem and what this might mean for the practice of counselling psychology. As will be explored below, counselling psychology is a discipline which has adopted a questioning stance towards what has been described as medical model of distress (Milton, Craven & Coyle, 2010; Strawbridge & Woolfe, 2003) which can create a tension when working with clients who have been given a diagnosis such as PTSD. In gaining the perspective of those with the diagnosis, this study hopes to cast light on how those not in the business of psychology speak about diagnosis and therapy, and think about what the implications of this are for counselling psychologists.

To this end, the next section will explore the existing literature on PTSD, outline in more detail the epistemology of the differing approaches to understanding mental health, and examine the conceptualisation of trauma, problems with diagnosis in general, and PTSD in particular. Finally, the researcher's position as a counselling psychologist in training will be discussed, along with how this position impacts and affects the epistemology of this research.

3. Literature Review

3.1 Post-traumatic stress disorder (PTSD) and existing research

Military psychiatry is generally considered to have started during the First World War of 1914-1918 with the issue of shell shock. There was a suggestion, however, of the possible repercussions of war for mental health as early as 1824 when the Vagrancy Act was passed in the aftermath of the Napoleonic War. This was designed to stop veterans exposing their war wounds to the general public. However, despite a variety of conceptualisations of this issue over the years, including wind contusion, nostalgia and disordered action of the heart (Jones & Wessely, 2005), formal recognition did not arrive until 1980 when the American Psychiatric Association (APA) first recognised PTSD as a psychiatric diagnosis.

Today, a diagnosis of PTSD according to the *Diagnostic and Statistical Manual of Mental Disorders IV – Text Revision* (DSM IV-TR, APA, 2000), requires meeting two stressor criteria: that serious harm was inflicted, threatened or witnessed and that the individual's response involved fear, helplessness or horror. Symptoms from each of three symptom clusters must also be demonstrated: intrusive recollections; avoidant/numbing behaviours; and displaying symptoms of hyper-arousal e.g. difficulties falling or staying asleep and outbursts of anger. These symptoms must be considered to cause severe impairment of day to day functioning and endure for longer than a month. Duration of over three months would lead to diagnosis of chronic PTSD. The National Institute for Clinical Excellence (NICE, 2005), has estimated that up to 30% of people who experience a traumatic event may subsequently develop PTSD, although statistics such as this should be treated with caution given the variance in PTSD prevalence depending on the diagnostic criteria used (O'Connor, Lasgaard, Spindler & Elkit, 2007). This issue is discussed in more detail below.

Recent wars and the increasing involvement of civilian populations in war (e.g. the London terrorist bombings in July 2005) have led to an increased awareness of PTSD (Joyce & Berger, 2006) and the lifetime prevalence of the disorder is now estimated to be approximately 6.8% (Harvard School of Medicine, 2007). The potential seriousness of the consequences for civilians exposed to trauma, war related or otherwise, has been well documented (see Kashdan, Morina & Priebe, 2009; Summerfield, 1997), and much research has been carried out into prevalence, possible causes and risk factors and effects (Joyce & Berger, 2006; Kashdan et al., 2009; Bracken, Giller & Summerfield, 1995).

PTSD is also characterised by its frequent comorbidity with other disorders, most commonly depression, substance abuse and other anxiety disorders (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995). In fact, Kessler et al. reported that 88% of men and 79% of women with PTSD also meet the diagnostic criteria for another mental disorder. Bradley, Greene, Russ, Dutra and Westen (2005) go as far as to argue that comorbidity with PTSD is the rule rather than the exception and that that this makes it hard to generalise about the efficacy of PTSD treatment.

Nonetheless, a number of options are available for treatment although there has been no clear consensus as to the most effective. NICE guidelines (2005) recommend trauma-focused cognitive behavioural therapy (CBT) in the first instance, although other trauma-focused treatment methods such as eye movement desensitisation and reprocessing (EMDR) are also recommended when symptoms have been present longer than three months. Pharmacological treatment is not considered a first line treatment although can be offered under certain circumstances, such as individual difficulty with engaging in trauma-focused psychological treatment or if this treatment has not proved beneficial. The guidelines are supported by Bisson et al. (2007) whose meta-analysis also found trauma-focused CBT and EMDR to be the most effective treatments and argue that drugs should therefore be a second line treatment. They argue that it is the focus on the traumatic event which is helpful but do acknowledge the potential difficulties for clients in reliving their trauma.

Van Etten and Taylor (1998) too support psychological therapy, specifically behaviour therapy and EMDR, over drugs as they found it has a higher rate of symptom reduction and a lower dropout rate. SSRIs and Carbamazepine were also found to be effective but tended to have a higher rate of attrition. Meta-analyses conducted into the efficacy of psychotherapy for PTSD have found that it is effective (Bradley et al., 2005) and these benefits are equivalent across psychotherapeutic forms (Benish, Imel & Wampold, 2008). Bradley et al. (2005), however, cite problems with generalising findings relating to PTSD because of the heterogeneity of PTSD symptoms, and the ambiguity of findings given that an individual can remain highly symptomatic despite dropping below the diagnostic threshold.

Other studies have focused on different treatment options such as early intervention. Research into the benefits of debriefing has produced mixed results and there are arguments that it could even exaggerate symptoms or delay their presentation (see Raphael, Meldrum & Macfarlane, 1995 for a review). More successful results have been found with the treatment of acute stress disorder (ASD). ASD was developed as a diagnosis to identify people at risk of developing PTSD in the long term, and Bryant, Harvey, Dang, Sackville and Basten (1998) have found that symptoms could be significantly reduced if treated with CBT within two weeks of the trauma. Many of these studies, however, highlight that veteran populations suffering from PTSD are often the most difficult to treat (Bisson et al., 2007; Bradley et al., 2005; Milliken, Aucherlonie & Hoge, 2007) suggesting that combat-related PTSD needs to be considered as a category of its own.

Much of the research into combat-related PTSD has focused on whether or not combat specifically is harmful to mental health. Hacker Hughes et al. (2005) found that war was not necessarily psychologically damaging suggesting that if the conditions are right (for example, highly trained and selected troops are used, morale is high and outcomes are successful), there do not have to be negative mental health side effects. Similarly, Hoptopf et al. (2006) did not find that the prevalence of mental health disorders was affected by whether a soldier was deployed or not.

But Kashdan, Morina and Priebe (2009) argue that 'individuals exposed to war zone-related traumatic events are at heightened risk for a variety of psychological problems including post-traumatic stress disorder' (p.185) and there is evidence to support this. Hoge et al. (2004) found that the prevalence of PTSD was significantly higher post-deployment than it was pre-deployment, with as many as 9% of soldiers at risk of a mental health disorder pre-deployment, rising to 11-17% three to four months post-deployment. Soloman, Weisenberg, Schwarzwald and Mikulincer (1987) found that 59% of combat stress reaction casualties developed post-traumatic stress disorder a year after the Lebanon War of 1982. Hoge, Auchterlonie and Milliken (2006) found that mental health problems reported on a post-deployment assessment completed by soldiers returning from Iraq and Afghanistan was significantly associated with combat experiences (along with referral and utilisation of mental health care and attrition from military service).

From this primary level debate, a more nuanced picture has begun to develop about different factors which affect mental health issues post combat. For example, perhaps unsurprisingly, high levels of combat exposure have been found to lead to significantly higher rates of PTSD (Hoge et al., 2006; Hoptopf et al., 2006; Price, 2006), likewise the having been wounded or injured (Hoge et al.). Studies have also reported significantly higher rates of mental health concerns for reservist soldiers than regular (Hoptopf et al, 2006; Milliken et al., 2007). It is also possible that the area or theatre of war could have an effect (Hacker Hughes et al., 2005), although this could, however, be linked to the level of combat exposure. Hoge et al. (2004) found that participants meeting screening criteria for a mental health problem (major depression, generalised anxiety or PTSD) were significantly higher after Iraq than Afghanistan. They also found a linear relationship between combat experiences (being shot at, handling dead bodies, knowing someone who was killed and killing an enemy combatant) with the prevalence of PTSD. Others have suggested that helplessness or lack of control during combat could contribute (Howorth, 2000; Moran, 2007; Rivers, 1918) and Spira, Pyne and Wiederhold (2007) have added that the unconventional type of warfare could also be a factor.

More controversial have been theories about the causes of combat-related PTSD that relate to the individual rather than combat. McNally (2010) points out that focusing on the individual rather than the stressors had been avoided because of the implication of fault or blame that consequently seemed to lie with the victim. However, he also cites a study by Koenen et al. which found that PTSD almost never developed unless the individual had previously been diagnosed with another psychiatric disorder. Wessely (2005) points to a number of possible causes relating to the individual including ill health during conflict, upbringing, genes, social climate and number of causalities encountered. Moran (2007) in his seminal work written in 1945 based on his own experiences as a doctor in the trenches of the First World War proposed an individual store of courage, like a bank account. This can be continually depleted through a number of circumstances such as lack of rest, festering thoughts, monotony and death. As a finite resource, courage will eventually run out. He argues that it is the commanding officer's job to know his men and know when they are reaching their limit so they can be rested in time. Kingsley (2007) points to Fairburn's psychodynamic explanation of trauma where the event reactivates old wounds from previous trauma, often from childhood.

There are also social explanations for possible psychiatric problems. The importance of the community in the armed forces cannot be stressed enough. Janis (1968) has argued that external danger increases group solidarity to the extent that combat troops will frequently act in the accordance with the needs of the group rather than their own self-interest. He bases this on the idea that group identification activates a set of pre-conscious or unconscious attitudes which lead to a perception of the group as an extension of self, and a Freudian understanding of the emotional bond between group members and their leaders as parent surrogates. Attachment to these surrogates prevents the onset of reactivated separation anxiety in the same way that exposure to danger promotes affiliation to group norms and standards to create reassurance that significant people will not leave.

Shay (1995) understands the Armed Forces as a social and moral construction based on shared values and expectations that are binding and morally strong enough to motivate the risking of life. He has highlighted the limitations of the English language in describing this bond and Kingsley (2007) agrees, going as far as to say 'language seems to fall short in describing the unique bond that forms between soldiers in battle' (p. 53). Kingsley points to Fairburn to explain how the breaking of this bond, such as when an individual reaches their stress tolerance level and starts to panic, can cause a breakdown of the unit's bond, a drop in morale and possibly even the collapse of the army in the field. That authority figures cannot protect you fits with Shay (1995) and Moran's (2007) understanding that being let down by a commander officer can lead to problems as it links to a betrayal of what is morally right. Wessely (2005) expands this idea of the social group to include the social and political climate of a soldier's home country as a risk factor – a lack of perceived interest and support can lead to problems, as is discussed further below with reference to the Gulf War Syndrome of 1991.

The effect of the loss of this group on leaving the Army is explored by Shay in his book *Odysseus in America: Combat trauma and the trials of homecoming* (2002) but it has not been sufficiently covered by research. Perhaps the best way to underline the importance of the soldier's social world is to look at some of the explanations given to explain why reservists report higher levels of PTSD than regular forces. These include the lack of daily support from comrades and added stress of the transition from civilian life and employment and back again (Milliken et al., 2007). Hotopf et al., (2006) add the potential lack of family support or understanding for their role in the military, unfamiliar units and greater exposure to public questioning of the war on their return.

Other reasons are suggested too, such as concerns over implications for health insurance and feeling untrained for the work, but the emphasis seems to be on the fact that the social unit is less familiar and secure. On a wider social and political level, Horn et al. (2006) suggest that the reason we have not seen a Gulf War Syndrome after the most recent Iraq war in contrast to 1991 could be related to the changes in concern; this time, governments and the general public are perceived as caring about the health of the Armed Forces.

Another facet of combat-related PTSD is its delayed manifestation, often only presenting years after the traumatic event has taken place (de Vries, 1998; Kingsley, 2007). Wessely (2005) points out that the Vietnam War was initially seen as a success story in terms of psychiatric health but this changed in the months after the war. A number of explanations have been offered for this: that the shock began to wear off; that the specific counter-guerrilla training Vietnam soldiers were given discouraged emotional expression including grief; or the abrupt removal from the active duty military support system that many veterans experienced (Kingsley, 2007). Or it could have been that once simply surviving had stopped being the priority psychiatric problems began to show (Wessely, 2005). This fits with Maslow's (1943) work on a hierarchy of needs which argues that it is only once the more basic needs at the bottom levels of the hierarchy (safety, shelter, food) are met that psychological needs nearer the top of the hierarchy are given greater focus. It is also backed up by statistics. For example, McNab (2008) highlights the fact that more soldiers who fought in the Falklands War in 1982 have committed suicide since the war ended than were killed during it. De Vries (1998) points out that according to some statistics, this is almost the case with the Vietnam War too, where 60,000 American soldiers were killed during the conflict and 50,000 have committed suicide since their return. These statistics should be viewed with caution given the duration of the conflict compared to the length of time post-conflict, but they are worrying nonetheless.

As outlined above, there is little consensus over the best method of treating PTSD and this is no different for combat-related PTSD. It also has the same issues with comorbidity (Creamer, Morris, Biddle & Elliot, 1999), especially depression and alcohol misuse which Wessely (2005) suggests is arguably a bigger problem for the armed forces than PTSD. Elhai, Frueh, Davis, Jacobs and Hamner's study (2003) demonstrates the variety in cause, manner and consequence of breakdowns related to combat-related PTSD and they argue that the heterogeneity in symptoms should be reflected in treatments which are flexible enough to meet the differences in need.

Shay (1995) argues that listening is the key, that healing stems from communication of the trauma in a safe environment and this would support the idea of psychological therapy. Its advantage is that each client can be worked with on a one to one basis meaning that the work can be modified and adapted to suit each client as an individual.

Therapy for combat-related PTSD however, does not have to be undertaken after the soldier has left the military. Solomon and Benbenishty (1986) outline a treatment method based on the French practice of forward psychiatry developed in the First World War (Jones & Wessely, 2005). This treatment is premised on the principles of proximity, immediacy and expectancy (PIE) where soldiers are treated close to the field of combat, as soon as possible after the presentation of symptoms and under the expectation that they will quickly return to their unit. They demonstrate that the cumulative effect of these three principles is to maintain the soldier's military identity while enabling him to overcome a crisis without severely interrupting his normal duties.

Rivers (1918) too treated men with the expectation that they would return to military duty, albeit back in the UK rather than at the front. His experiences at Craiglockhart War Hospital during the First World War treating patients such as Wilfred Owen and Siegfried Sassoon convinced him that problems were not caused by war experience itself but by the attempt to repress difficult memories or painful emotions. He argues that this repression created conditions which made it impossible for the individual to adapt and led to the appearance of other symptoms, such as nightmares or somatic manifestations such as mutism or paralysis. He found that these symptoms frequently disappeared when the individual stopped trying to repress their memories.

Group therapy for combat-related PTSD started with Bion (1961) during the Second World War. He approached individual neurosis through treating group issues and making those issues the responsibility of the group rather than the responsibility of himself or his staff. Kingsley's (2007) review of group treatment argues that it is uniquely suited to veterans because the group mimics the *esprit de corps* that veterans have known as soldiers, as opposed to the potential sense of isolation fostered by individual treatment. This communalisation of trauma creates a context for re-establishing the trust lost through the failure of the chain of command to protect soldiers from the psychological consequences of war. The group structure also negates possible issues with authority that also stem from this same issue.

These ideas fit with David Clark's view of PTSD (Roth, 2010), where he points out that going over experiences of trauma in therapy can feel like a re-traumatisation leaving the client feeling like a victim again. To counteract this, the therapist needs to be explicitly warm and empathic to create a safe space for the person, arguably the same safe space created by a group who have been through similar experiences.

Other therapeutic options include short stay programmes which have produced encouraging results (Creamer et al., 1999) and experiential approaches to treatment, especially virtual reality-assisted exposure therapy. Spira, Pyne and Wiederhold (2007) argue that these can be helpful additions if used within a therapeutic framework.

But it is also important to recognise that in treating this particular client group, a crucial first step is overcoming the stigma of asking for or receiving help. In an environment which prizes courage, asking for help could be seen as a threat to identity. Vogel and Wade (2009) categorise this as self-stigma and this is symptomatic of the military where unique factors, such as the strength of relationship between comrades exist to prevent soldiers asking for help. Bracken et al (1995) have highlighted the importance of taking the political, social and cultural context of an event into account if treatment is to be effective, and the Armed Forces must represent a very specialised context. Only 23-40% of soldiers who tested positive from a mental disorder seek healthcare (Hoge et al., 2004). It seems ironic that this stigma appears especially ingrained for members of the armed forces given that it is they who are subject to more consistent and longer lasting traumatic events than any other group. Even more so that concern about stigma is higher amongst those who need help than those who do not (Hoge et al.). There have been some encouraging reports of family members, especially spouses, seeking health care on behalf of those suffering (Milliken et al., 2007) and a possible general increase in the reporting of symptoms has also been noted (Horn et al., 2006). Largely, however, the problem remains, and calls have been made for more work to be done towards lifting the stigma that overshadow asking for help (McNab, 2008; Wessely, 2005).

Possibly related to this issue with stigma, studies have also found that there is frequently a delay in reporting symptoms (Hoge et al., 2006; Milliken et al., 2007; Solomon et al., 1987). These issues are exacerbated by the fact that veterans have not found talking about their experiences to be a uniformly positive process. In reality, they find it difficult to disclose what they have been through, and full disclosure is rare (Leibowitz, Jeffreys, Copeland & Noël, 2008). Thus, gaining the perspective of the veterans on their therapy represents an important first step in beginning to understand what treatment means to them and how they understand it.

3.2 Conceptual issues with diagnosis, trauma and PTSD

Diagnosis for mental health problems comes from a medical model based upon an understanding that truth exists and can be known - the epistemology of positivism. Positivism has a long history which has been subject to change over time (for example, see Willig and Stainton Rogers, 2008, on positivism's history as a radical critique in reaction to religion and metaphysics). But despite debates over how or what constitutes incontrovertible proof, positivism today is based on an understanding that reality exists and can be discovered through application of the right method of research, 'the conviction that scientific knowledge is both accurate and certain' (Crotty, 1998, p. 27). In practice, this means laboratory experiments, randomised double blind controlled trials, quantitative data, proof and objective fact (Willig & Stainton-Rogers, 2008). Diagnosis assumes then that a disease exists independently in the world, regardless of whether it has been 'discovered' (Summerfield, 2001).

The APA's *Diagnostic and Statistical Manual of Mental Disorders IV – Text Revision* (DSM IV-TR, 2000) is symbolic of this positivist position, covering mental health disorders, causes, breakdown by gender, age of onset, prognosis and research about treatment for adults and children. The advantage of this model is that it provides a universal language across professionals in different fields. Its multi-axial approach includes psychosocial problems and physical conditions, and therefore does try to provide a complete picture of the individual and their context. But this is a top down process that too often starts with an individual's symptoms, rather than the individual.

This is not the only criticism that has been levelled at the concept of diagnosis for mental health issues. Boyle (2007) points out that it is fundamentally flawed because it is based on the premise that psychological problems will follow predictable patterns and frameworks in the same manner as physical illnesses. With this understanding, diagnostic concepts are thought up rather than stemming or emerging from data or experience. The data that does exist is moulded into these pre-existing categories. In reality, people's behaviour and emotions do not fit easily into categories, hence why they are not good predictors of outcome. Attempts to put individuals and their behaviour into frameworks have a number of consequences including increased pathologising through dual diagnosis or comorbidity and little attention paid to the actual experience of suffering leading to a lack of depth in understanding. It also means that what could be considered normal responses of coping mechanisms for distress are turned instead into mental disorders. Where is the line at which the everyday difficulty or distress becomes illness, and who draws it (Summerfield, 1999)? Worries such as these about the stigmatisation of eccentricity have been in the news recently in response to work on the fifth version of the DSM, scheduled for publication in 2013 (see Jarrett, 2011, for example).

Despite this emphasis on fact, however, this view of science is not static: 'the significant changes in science appear to have occurred through radical shifts in the way scientists view reality' (Crotty, 1998, p. 36). These shifts are linked to changes in cultural perceptions and understandings, for example, the 1960s move away from community values to a growing emphasis on the individual. At the same time, emotional expression gained increasing prominence over keeping emotion under control and hidden from others (Wessely, 2005). PTSD is no exception to this. The overview above of the existing literature on PTSD is a reflection of a contemporary understanding of the diagnosis. But a look back into its history would reveal the extent of the changes in the conceptualisation of this mental health problem which have occurred over time and across cultures. Perhaps the best or most famous demonstration of this is that 95 years ago during the First World War, exhibiting the symptoms of what we now call PTSD could lead to a court martial and execution for cowardice (see Jones & Wessely, 2005, for a complete history of changing attitudes in military psychiatry).

So psychiatry and psychology are subject to fashion, and diagnosis and treatment reflect the clinical perspectives of their time (Kingsley, 2007). Positivism has been the dominant discourse for some time, but recent shifts have seen the growth of an ever more questioning stance taken by

practitioners and researchers in psychology, who are no longer accepting the notion of science at face value. For PTSD, these kinds of questions are relevant in a number of areas, including the assumptions that lie behind PTSD, the concept of trauma itself and on a wider level, whether PTSD can be considered universal or is it culturally specific to the west?

Rosen and Lilienfeld's (2008) empirical evaluation of the assumptions behind PTSD concluded that 'virtually all core assumptions and hypothesises mechanisms lack compelling and consistent support' (p. 837). While they do not question the distress felt by sufferers, they do question the conceptualisation of this distress offered by PTSD. This is broken down into three categories.

Firstly, issues with the assumptions that a diagnosis of PTSD makes about its aetiology. A criterion A stressor (that serious harm was inflicted, threatened or witnessed) is necessary for a diagnosis but not sufficient on its own, because it does not always lead to a fearful or distressed reaction. But questions have been asked about whether this kind of stressor is in fact necessary, and further, the extent to which these stressors actually contribute to pathology – i.e. how far the magnitude of the trauma is linked to the magnitude of the distress.

In fact, the inclusion of the criterion A stressor for a diagnosis of PTSD has caused a number of problems. PTSD is one of very few diagnoses that make any specification about the aetiology of a mental health problem (Joyce & Berger, 2006; McNally, 2010). Since the publication of DSM III in 1980, the events that are considered to possess the capability of causing PTSD have been greatly expanded. This bracket creep has led to a diagnosis which simultaneously covers concentration camp survivors and giving birth to a healthy child or watching a traumatic event on television (McNally, 2010; Summerfield, 2001; Wessely, 2005). McNally adds that the broader the criteria are the less significance can be given to them and the more which must be attributed to other factors, such as the vulnerability of the individual. This raises again the issue discussed above regarding blame.

Secondly, Rosen and Lilienfeld (2008) examine evidence that suggests that PTSD is not actually a distinct disorder. Its frequent comorbidity with other disorders has been outlined above, but in addition to this, they point out that the necessary criteria for PTSD are so broad that two people could present with an entirely different set of symptoms and still be given the same diagnosis.

Finally, and on a similar vein, Rosen and Lilienfeld (2008) outline research attempts to find a distinctive biological marker for PTSD. These include neuro-endocrine findings, neurocircuitry (increased blood flow in certain areas of the brain specific to a certain disorder), and psychophysiological reactivity, all of which have produced inconclusive results. It also includes the suggestion that traumatic memory, or dissociation from it, is unique to PTSD but again, this is difficult to test and results have not been conclusive. Critics have pointed out that this is true of many diagnoses including schizophrenia and depression (Herbert, 1998), but for Summerfield (1998), it is further evidence that PTSD, and the idea of traumatic memory, was created rather than discovered. He argues that those who believe that PTSD is fact 'must believe that from the cave wars of Neolithic man onwards, people exposed to shocking events had been liable to a psychiatric condition which only in 1980 had been fully discovered, named, and classified' (p. 1580). Rosen and Lilienfeld caveat their findings with the acknowledgement that some of these issues are not unique to PTSD and that there is still research to be carried out in this area.

Despite this, their work serves as an effective reminder that diagnosis is not an absolute science. This is strengthened further by O'Connor, Lasgaard, Spindler and Elklit (2007) who highlight the difference in the prevalence rates of PTSD depending on whether it is diagnosed using the DSM, as discussed above, or using the World Health Organisation's (WHO) International Classification of Diseases, now in its tenth revision (ICD-10, 1992). They point out that this discrepancy could result in the diagnosis losing its credibility, especially in countries where the DSM is used for diagnosis and the ICD for practice.

This is only one of many issues which Richardson, Frueh and Acierno (2010) outline in their review of the difficulties encountered in estimating the prevalence of combat-related PTSD. As well as this issue with the DSM criteria, they point to sampling strategies (including sample size, selection bias and comparison groups), measurement strategies, timing of assessment (taking recall bias into account), and the experience of combat, before during and after deployment all of which make it difficult to generalise about the epidemiology of combat-related PTSD. Other factors to consider include socio-political and historical factors, such as the influences of the possibility of compensation or disability payments (Frueh, Hamner, Cahill, Gold & Hamlin, 2000), media influences on symptom reporting, issue of the course of PTSD over a lifespan, and co-morbidity, which has been discussed above (Richardson, Frueh & Acierno, 2010).

Some of these issues for PTSD are related to how it was originally conceived. The diagnosis came into being in the aftermath of the Vietnam War, the product of the anti-war movement's fight to have soldiers recognised as victims rather than perpetrators of atrocities (Summerfield, 1999, 2001). This meant that moral blame could be shifted to the government that sent them to Vietnam, and away from the men themselves (McNally, 2010). As such, PTSD can be understood to be the product of political or even social movements rather than medical evidence: 'a non-disease shaped as much by social concepts as psychiatric ones' (Summerfield, 2001, p. 97).

Embedded within PTSD are assumptions about how much a person can face and what their reactions in the face of trauma should be. Summerfield (2001) argues that this can create a self-fulfilling prophecy where people react a certain way in order to fulfil expectations. On a wider level, it also makes assumptions about individuality. Bracken, Giller and Summerfield (1995) underscore the way in which the western emphasis on the individual has perpetuated a biomedical discourse about distress and trauma which, together with an aetiological focus on premorbid personalities and traumatic events, is in danger of underestimating the importance of psychological, political and economic factors. These attempts to separate the intra-psychic from the interpersonal and somatic reactions can lead to an isolating experience for the individual. In a later paper, Summerfield (1997) outlines this further, pointing out that the conflation of trauma and distress in the west has led to distress being 'medicalised' (p. 1568) and consequently treated with talking therapies in the same way that a broken leg might be set in a cast or chemotherapy administered for cancer. There is no empirical basis for this and the labelling of distress as pathological does not necessarily benefit sufferers.

Joyce and Berger (2006) agree that PTSD is the product of a western emphasis on the individual and individual happiness. They argue further that the dominance of western culture in trauma literature has meant that pathogenic aspects have been stressed over possible benefits and the potential for growth. The assumption that mental disorders are universal (Bracken et al., 1995) ignores the fact that cultural responses to trauma vary greatly across many levels, including the perception of trauma, how it is understood, coped with and come to terms with. What one person might view as a pathological reaction is seen as an understandable reaction by someone else. This creates a serious risk of misdiagnosis which could lead to an inappropriate treatment that does not take cultural variations into account.

De Vries (1998) argues that these issues should not stop westerners from trying to help if this is done in a sensitive way, and points out that today's PTSD diagnosis has come a long way from previous labels such as battle-shock, or disordered action of the heart (Jones & Wessely, 2005). Despite this, however, it is clear that questions remain about the accuracy and adequacy of this diagnosis.

Bracken et al. (1995) have proposed a different model of looking at trauma which places social (for example family and social networks, employments, economics), political (e.g. party affiliations, class, ethnicity) and cultural (e.g. spirituality and religion, concepts of self, illness and community, ontological beliefs) realities in central focus. These realities provide a contextual framework through which the subjective meanings of violence and trauma, the way they are experienced and reported, the type and extent of general support and the therapeutic support which is both available and appropriate can be considered. This model provides an alternative view point, but critics might argue that this is a difficult model through which help can be provided on a large scale. If there is no diagnosis it can become difficult to estimate numbers suffering who need help, plan treatment programmes and budget financially.

The other issue to consider is that Bracken et al.'s (1995) argument is based on civilian populations to whom war has happened; it has been inflicted on them through no choice or fault of their own. If we are taking context into consideration it should be vital to consider the fact that active members of the armed forces today are all volunteers. They have self-selected to be part of a unit which in today's political climate means almost guaranteed active service. McNally (2010) has highlighted the fact that, however under-researched it is, the category of self-traumatised perpetrator exists – it is possible to be traumatised by your own actions. He is speaking in relation to people who have carried out atrocities, but can the same apply to volunteers of the armed forces? Struggling to cope with trauma can be seen as a normal reaction to an abnormal event, but if you are voluntarily part of a fighting force, can or should traumatic events be considered normal?

3.3 Epistemological concerns and counselling psychology

This debate about how to conceptualise what we currently call PTSD is symptomatic of a wider epistemological debate between the medical model of diagnosis and counselling psychology. Counselling psychology is a discipline which initially developed outside of mainstream psychology and is perhaps unique amongst psychological and psychotherapeutic disciplines in its incorporation of the distinct epistemological worlds of psychology as science and psychology as therapeutic (Orlans & Van Scoyoc, 2009). The challenge of this is demonstrated by the breadth of the British Psychological Society's (BPS, 2010) and the Division of Counselling Psychology's (DCoP, 2005) definitions of the profession. It is 'strongly influenced by human science research as well as the principal psychotherapeutic traditions […] draws upon and seeks to develop phenomenological models of practice and enquiry in addition to that of traditional scientific psychology […] and develops models of practice and research which marry the scientific demand for rigorous empirical enquiry with a firm value base grounded in the primacy of the counselling or psychotherapeutic relationship' (DcoP, p. 1).

Thus, inherent within counselling psychology are tensions between these two sides, so much so that Orlans and Van Scoyoc (2009) have argued that given the breadth in focus and wide range of ideas contained within counselling psychology, its identity might be best 'encapsulated by the capacity to *hold* tensions rather than resolve them' (p. vii). Despite this, Strawbridge and Woolfe (2010) have identified three main areas which distinguish counselling psychology from other disciplines and form a foundation of values which underpin the manner in which counselling psychologists can approach both theory and practice. These are: a growing awareness of the role of the therapeutic or helping relationship; a questioning stance towards the medical model of professional-client relationship; and a move towards a more humanistic base, and an interest in promoting well-being, rather than focusing solely on sickness and pathology (p. 4).

Thus, despite this straddling of worlds, counselling psychology has maintained its questioning stance towards a top down, medical model of distress, arguing that it denies personal responsibility, distances sufferers from their experiences through the use of technical language and does not take their economic, social or political contexts into account (Strawbridge & Woolfe, 2010). Instead, counselling psychology has positioned itself as a proponent of the first person subjective with a focus on facilitating well-being and recognition of the importance of the role of the relationship in

therapeutic work (Strawbridge & Woolfe, 2003): “the meanings, beliefs, context and processes that are constructed both within and between people and which affect the psychological wellbeing of the person” (BPS, 2010).

Thus, inherent within the ethos of counselling psychology is a recognition that a person is so influenced by their own experience, culture, history, personality and relationships (Crotty, 1998) that they cannot objectively perceive another person or object. This idea is also proposed by Rorty (1989) who makes a distinction between the world that we live in versus the truth that we each individually make of it. If the truth is an individual construction, whose version is best? Whose knowledge is privileged and who has the power to define the problem (Summerfield, 1999)?

Diagnosis is one way of seeing things and prevailing medical and empirical attitudes mean that current research into PTSD is conducted in this manner. But it is important to remember that from a counselling psychology perspective, these ‘objective’ forms of research are as constructed as any other, they are equally as embedded in the social, political and historical thinking of their time (Orlans & Van Scoyoc, 2009). Outlined in the following section is a discussion of how to evaluate work conducted from an epistemological position that does not recognise science as fact, objective and impartial. This focuses on the commitment and coherence to a particular philosophy throughout a piece of work. On this basis, the studies outlined above are relevant because they have followed this different theoretical path consistently, thus maintaining their validity. They are the product of their own world too.

What they lack, however, is the perspective of those who actually suffer from this problem. The difficulties outlined above in providing treatment to this population highlight the need to consult the service users. That veterans themselves have not been consulted is a result of this prevailing opinion about how knowledge is generated and used. But as discussed here, this method is flawed. The veterans in this research have made their own sense about their experiences but despite this they have each been given a medicalised version of their distress: a diagnosis of PTSD. PTSD is one method of describing what is happening, it cannot and does not encapsulate the individual subjective experience. The truth of this experience will be different for each veteran, likewise their experience of the treatment they receive.

3.4 Research aims

This study aims to answer the research question how do veterans diagnosed with combat-related PTSD experience therapy? In answering this question, the primary intention of the research is to hear the participants speak, to allow them to describe as fully as possible the process of conceptualising and meaning making involved in their experiences and subsequent understanding of therapy.

Through asking this question, this work also hopes to take a first step in creating a more balanced body of opinions on the treatment of this particular human condition. It is also possible that something might emerge which contributes to the debate over the best approach to mental health which might, in turn, help counselling psychologists meaningfully negotiate the path between the medicalised and individual versions of distress and think about this means for future practice.

Epistemologically, I have argued above for a form of constructed reality that exists for an individual, but which is shaped intrinsically by the social, political, historical, cultural and environmental factors of that individual's past and present. It was important, therefore, to find a research methodology which would be faithful to both this version of reality while allowing the research question of this study to be answered: how do veterans diagnosed with combat related PTSD experience therapy? This is discussed in the following section.

4. Methodology

The literature review above argues a case for a adopting a questioning stance towards PTSD, trauma and diagnosis. It highlights some of the issues with privileging a fact-based or 'scientific' understanding of the world we live in and the phenomena we experience which mirrors counselling psychology's more individually focused and contextual stance (Strawbridge & Woolfe, 2003). This stance is not limited to the diagnosis and treatment of mental illness, however; the same questions have to be asked of research epistemologies, methodologies and methods too. The following section will explore my personal reflexivity on the underlying epistemology of research methodologies within the context of this research. The consistency of this position with the epistemology of counselling psychology is examined, and will be used to illustrate decisions about the methodology and method of this research. Finally, the practical details of how this research was completed are outlined, along with issues of validity, ethical considerations and personal reflexivity on the research topic.

4.1 Personal epistemological reflexivity in the context of this research

The debate over epistemological paradigms has a long history (see Crotty, 1998; Willig, 2001), and the development and changes to theory over time have been discussed above in relation to positivism. These kinds of changes can also be seen in the differences between Crotty's epistemological positions of objectivism, constructionism and subjectivism and those of Henwood and Pidgeon (1994) of empiricism, contextualism and constructionism. Clearly then, epistemology is not a science of absolute categories with universally agreed meanings and parameters. The relationship between truth, reality and meaning is complicated and the overlapping nature of some of the epistemological positions is a reflection perhaps of the 'essentially ambiguous character of human knowledge' (Crotty, p. 30).

Trying to understand my own epistemological position has been a reflexive process; becoming aware of something that I had previously been immersed in, but not been explicitly conscious of or examined in detail. This is a process of recognition that highlights my understanding of my social and psychological world views; the fundamentals of how and what I understand the world, and knowledge, to consist of.

My position within this debate has emerged from my perception and understanding of mental illness as a trainee counselling psychologist. This has been outlined above but starts with the individual and their context as the primary focus, rather than the diagnosis which the client might arrive with. In this study, I have found myself privileging the client's story, their understanding of the nature of their distress, its impact and the sense they make of it; a stance characteristic of contextual constructionism. According to Madill, Jordan and Shirley's (2000) definition, the contextual aspect of contextual constructionism understands knowledge as 'local, provisional and situation dependent' (p.9). They argue that constructionism means that there is no one reality to be revealed by using the 'correct' methodology because human beings are conscious and meaning-making, constantly acting on the world around them and making sense of it in unique ways. This is a creation of meaning through the interaction of subject and object, an individual engagement with the world which explains why meaning is different for everyone, even in relation to the same phenomena (Crotty, 1998). This also accounts for how and why the meaning of objects changes over time, because meaning is influenced by the perspective of the person perceiving it and that person will be a product of their cultural and social context (Lyons, 2007; Madill, Jordan & Shirley, 2000). For research purposes, this position acknowledges that results collected will be influenced by a number of factors. These include both participants' and the researcher's meaning making systems, their cultural backgrounds and also the criteria by which research is judged by a wider psychological community (Henwood & Pidgeon, 1994).

Madill, Jordan and Shirley (2000) acknowledge that this position overlaps with that of critical realism where facts exist, or as Fade (2004) phrases it: 'there are stable and enduring features of reality that exist independently of human conceptualisation' (p. 647). As with contextual constructionism, however, people are understood to interact with others and their world from within their own networks of cultural meaning, and will therefore have different beliefs and expectations (Madill, Jordan & Shirley, 2000). For this reason, and because individuals perceive different parts of reality (Fade, 2004), these enduring features will be perceived and interpreted differently. Thus, a critical realist position acknowledges that there are fundamental truths within the world, but, because there is subjectivity within knowledge, the experience of the world is different for each person. For contextualist purposes, this position allows research results to be grounded within the social practices and norms of the participants' world. This is especially important for this research given the significance and on-going influence of social norms within the military.

Critical realism's acceptance of the enduring features of reality also allows space for the idea that other people might be less concerned with how the world is constructed than I am. As a contextual constructionist I can acknowledge that my view is just that, mine, but that other people's views are both different and equally individual. My sense from having spoken to others during the process of understanding my position is that few question the established reality of their world, or think about how their understanding of knowledge is created: the influence of culture or background is not considered, and the existence of truth is often taken at face value.

If I want to honour the participant, therefore, if I want to research as closely as possible their experience, is it not important to acknowledge the reality that they live in rather than impose my understanding of the world? So I find myself somewhere between these two positions, a place which reflects both my understanding of the world and my professional stance as a trainee counselling psychologist.

4.2 Qualitative research and counselling psychology

The position outlined above meant that qualitative research methods would provide greater opportunity to maintain a coherent epistemological stance throughout the work. Qualitative research is not a homogenous field (Coyle, 2007). Indeed, there is a great variety of methods grouped under its umbrella covering a range of epistemological positions, political beliefs and ethical stances. McLeod (2001) argues that this is a result of its underlying belief that there are many alternative understandings of reality, as opposed to the belief that there is a single objective reality which can be discovered. These varying positions play a pivotal role in determining what research can discover, as will be discussed below with regard to the evaluation of research. Willig (2001) argues, however, that qualitative methods are linked by a shared concern with meaning. Specifically, the meaning making process of individuals and what this means for their beliefs and the way they experience events and relationships.

Qualitative research methods have a long history, characterised by their position on the outskirts of mainstream psychology (Coyle, 2007; McLeod, 2001; Willig & Stainton-Rogers, 2008). But they have gained increasing recognition academically, in research and by professional bodies (Smith, 2004; Willig & Stainton-Rogers, 2008). In counselling and psychotherapy, this is partly because of the opportunity that these research methods offer for insight into the depth of human thinking and interactions, a concern closely associated with those of more relational, individually focused therapeutic orientations (McLeod, 2001), including counselling psychology.

Hoyt and Bhati (2007) outline three reasons why qualitative methodology is compatible with the principles of counselling psychology. Firstly, they share the same ethos whereas quantitative methods are considered too closely associated with a positivist epistemology unsuited to investigating the depth of human experience. Secondly, the small sample sizes usually involved in qualitative research provide rich and deep descriptions about individuals and their experience which mirrors counselling psychology practice. This provides the means by which counselling psychology's commitment to evidence and research can be allied to its more humanistic approach to practice and thereby honours its commitment to a scientist-practitioner model (Strawbridge & Woolfe, 2010). Thirdly, these types of research lend themselves to studying rarely researched populations at a time when counselling psychologists have increasingly become aware of the importance of diversity, and their role in empowering or providing a voice to these populations, as well as being competent to both research and provide therapy (DCoP, 2005; Rafalin, 2010).

Morrow (2007) also highlights the links between qualitative research methods and counselling psychology, pointing to the congruence between qualitative paradigms and counselling psychology practice. Of her proposed qualitative research paradigms (postpositivism, interpretivism-constructivism and ideological-critical theories), she argues that the latter are particularly suited to counselling psychology because they share a constructivist view. The interpretist-constructivst paradigm also argues for individual realities (relativist) and co-constructed meaning between participants and researchers (or therapists and clients). This recognises a transactional world, where the researcher's subjectivity is both expected and included.

This relativist position acknowledges that there is a relationship between what someone says and the actuality of their experience. This is not considered to be perfect because memory is not perfect, and because each individual has made sense of a phenomenon individually. But it does assume the data that emerges from an interview with a participant does relate to some kind of reality about the experience being examined (Coyle, 2007). These assumptions are closely related to my preferred epistemological position of contextual constructionism and are a good 'fit' with the aims of research.

4.3 Interpretative Phenomenological Analysis (IPA)

IPA was developed by Jonathan Smith and associates (e.g. Smith, 2011; Smith, Flowers & Larkin, 2009; Smith & Osborn, 2008) as a qualitative research method designed to bridge the divide between traditional mainstream psychology and more qualitative or subjective experiences, so that psychology could embrace both the 'experimental and experiential' (Shinebourne, 2011, p. 17). As a research method it aims to explore in depth the 'personal lived experience, the meaning of experience to participants and how participants make sense of that experience' (Smith, 2011, p. 9). Premised upon the assumption that what people say directly relates to their experience, how they approach, connect to and understand the world they live in (Smith et al., 2009), IPA also recognises the influence of social, cultural and historical factors. This position, and its focus on experience and sense-making, arise from IPA's underlying roots in three key philosophies: phenomenology, hermeneutics and idiography (Smith, Flowers & Larkin, 2009).

As with research paradigms, phenomenology has a long history which there is not space for here (see Smith et al., 2009), but despite different interpretations and understandings across time, at its heart phenomenology remains concerned with lived experience and how we come to understand it (Smith, 2011). Thus, part of the phenomenological debate has been about the consciousness with which humans engage with their world. Although Larkin, Watts and Clifton (2006), for example, argue that Husserl's supposed dualism between the object and subject has been misunderstood, it is Heidegger's conceptualisation of interaction as intrinsic and fundamental to human beings that is more widely accepted and informs the practice of IPA today. Humans are understood to be embedded within a personal, individual world, but one that is the product of and fundamentally linked to the relationships held with it and within it.

Given this, phenomenological understandings have moved away from attempts to bracket off the researcher's way of thinking and seeing (Crotty, 1998), while maintaining a concern with getting as close to what is being described as possible. This means the phenomena has the best possible chance to be seen without the imposition of pre-conceived ideas (Larkin, Watts & Clifton, 2006), while acknowledging that there is no such thing as an objective view and the impossibility of describing anything independently of our relationship to it.

It is this process of seeing and describing the account of another which links IPA to hermeneutics. Hermeneutics has an even longer history than phenomenology, originating as the study of the interpretation of biblical texts. It is now concerned with the methods and purposes of interpretation more generally (Smith, Flowers & Larkin, 2009). IPA offers the possibility for several layers of interpretation and Smith (2004) argues that data analysis for IPA should allow the reader to understand the results on two levels: the individual accounts and themes that have emerged across participants. Further levels of interpretation are also possible within individual accounts through the dual strategies of empathic engagement and through a more critical stance which asks questions of the participants' accounts (Shinebourne, 2011).

Like the phenomenological position, hermeneutics also posits that all interpretation is filtered through the dual subjectivities of the researcher as well as the participant (McLeod, 2001). The researcher is understood to be a product of their culture and history as much as the participant, and as such, cannot stand outside of this to gain an objective understanding. As a result, IPA stresses the importance of the researcher's personal reflexivity across all aspects of the research process (Lyons, 2007; Willig, 2001), considering that this reflexivity is necessary to explore and acknowledge as far as possible the context in which an interpretation is made, and the pre-understandings or assumptions of the researcher (Smith, 2007).

Analysis, therefore, becomes what is known as a double hermeneutic. The researcher is trying to access the experience of the participant, while recognising that it is impossible to convey pre-reflexive experience as the very nature of narration involves reflexivity or sense making. Thus, the aim instead is to get as close as possible, rather than expecting to access personal experience itself. The researcher is making sense of the participant making sense of something (Smith, Flowers &

Larkin, 2009). In this way, phenomenology and hermeneutics are inextricably linked because 'without the phenomenological there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen' (Smith et al., 2009, p. 37).

This concern with the individual is reflected in the third key philosophy of IPA, that of idiography. Idiography comes from 'idios', concern with the individual (as opposed to 'nomos' – the 'law', or consistencies). An idiographic approach focuses on individual phenomena to trace their unique development and as such is concerned with depth and detail. IPA understands this on two levels. Firstly, in its commitment to detail in analysis, starting with one case and analysing it until some kind of closure is achieved (Smith, 2004). Secondly, in its commitment to the participants' understanding - how these specific people have understood a particular phenomenon in a particular context (Smith, Flowers & Larkin, 2009). This is a bottom up process, grounded in the real experiences and perceptions of the people interviewed.

Overall, IPA's epistemological background roots the methodology in a clear commitment to hearing from the participants, to allowing what is important to them to emerge (Reid, Flowers & Larkin, 2005) rather than trying to prove a pre-existing hypothesis. Participants are considered to be the experts on their own experiences (Smith, Flowers & Larkin, 2009) and it is these experiences which the research explores and engages with. Ultimately, IPA is committed to 'exploring, describing, interpreting, and situating the means by which our participants make sense of their experiences' (Larkin, Watts & Clifton, 2006, p. 110). It is this commitment which means IPA dovetails with some of counselling psychology's own philosophy, namely its engagement with subjectivity and inter-subjectivity and prioritisation of the individual or first person account (DCoP, 2005). Using IPA as a research method therefore maintains counselling psychology's commitment to ground its practice in research while honouring its demand for congruence between counselling psychology values and research methods (DCoP, 2005, Orlans & Van Scoyoc, 2009). The practicalities of this in real life, or the 'how' of IPA, is examined below.

4.3.1 Why not other qualitative methods?

The decision to use IPA was premised upon it being a good fit with the epistemology and research aims of the study. There were, however, alternative research aims, the exploration of which could have thrown light on a number of alternative areas within this research topic.

For example, in some respects, the focus in this study on the individual could be seen as neglecting the importance of the social world. This was a concern for this population given that the social world in which they operate as active soldiers - the Armed Forces - is such a crucial part of their identity. Indeed, as discussed above in the literature review, many consider the loss of this social world as one of the primary difficulties a soldier faces when he or she leaves the military (Shay, 1995). Using a different methodology would have allowed a focus on this more specifically. Grounded theory for example, is a methodology which encourages the understanding of individual behaviour within a social context (Charmaz & Henwood, 2008) and would have facilitated the research to identify categories, link and establish the relationship between them, and from this, form a theory about the nature of the social world of the soldier (Willig, 2001).

More language based approaches such as discursive psychology, discourse analysis and conversational analysis all could have led to different forms of exploring the role of language, such as within therapy; between participants (McLeod, 2001); its contribution to the construction of social reality (Willig, 2001); or how it maintains intersubjectivity (Wilkinson & Kitzinger, 2008). Narrative theory, on the other hand, is concerned with how human beings make sense of change (Murray, 2008) and this would have been especially relevant for former members of the Armed Forces given the gulf between active service and civilian life.

Choosing IPA was not a statement of rejection of these methods but recognition of where this research wanted to start. This is a field where the voice of the population has largely been overlooked in favour of more general, quantitative studies. This was therefore the first opportunity to hear what they had to say in any depth, what they wanted to say, rather than what has been said about them and this opportunity fits with counselling psychology's own commitment to hear from those who might previously have been unheard (Rafalin, 2010). Further studies can then build on this to create a wider picture by utilising other methodologies and these areas are taken up further in the discussion.

4.4 Validity and evaluation

Qualitative history goes back a long way (see Coyle, 2007; Willig & Stainton-Rogers, 2008) and its position as the alternative to more established quantitative approaches has meant that researchers have often felt the need to use quantitative evaluative criteria such as reliability and elimination of researcher bias to justify the worth of using a qualitative method (Coyle, 2007).

More recently, however, criteria have been developed that allow qualitative research, including IPA, to be judged on its own terms. Crotty (1998) makes a distinction between what is often considered a quantitative versus qualitative split into positivism versus non-positivism. He is making the point that it is not the methodology or method that distinguishes the position of a piece of work but its epistemology, the philosophy behind it. Thus it is the research paradigm and the researcher's commitment to it throughout their work which has come to determine the parameters by which a piece of research is evaluated (Coyle, 2007; Crotty, 1998; Morrow, 2007).

This includes an awareness of the kind of knowledge that the method used aims to produce (Willig, 2001) or what the method is attempting to achieve (Lyons, 2007). IPA aims to gain an in depth understanding of how the participants involved experience their world. As discussed above, this cannot be direct experience because it is the researcher's understanding of their account and as such, will inevitably be influenced by the researcher's subjectivity. But the influence of hermeneutics in IPA means that this subjectivity is not something that needs to be eradicated, or bracketed out, but can be seen as a precondition for coming to an understanding of someone else's experience. IPA maintains a commitment to getting as close to another's perspective as possible while recognising this. Therefore, appropriate evaluative criteria for IPA can include proof that the research has been carried out rigorously, is committed to grounding its findings within the words of the participants and that the researcher has engaged reflexively with the material to understand their own contribution (Lyons, 2007; Willig, 2001). Ultimately, McLeod (2001) argues that all of these forms of knowing are temporary; IPA can only be used to uncover or explore a person's current position in relation to the phenomena (Larkin, Watts & Clifton, 2006). The nature of qualitative work is constructed on the understanding that we cannot achieve a complete, scientific understanding of the world but we can aim for arriving at something which changes a current understanding, or opens up a new possibility.

This conceptualisation raises the issue of the use of research – should it be useful, and if so, to whom? Lyons (2007) outlines Willig's critiques of applying psychological research to real life situations. These include: legitimising research through claims of objectivity and science which prevents questions about the aims of applying these theories to life; the abuse of research by those in power to justify policy decisions; and the danger for oppressed groups in certain meanings or understandings becoming entrenched and thereby becoming more disempowering than empowering.

Despite the variance between the different qualitative methods, guidelines for evaluative criteria now exist which can be applied across the different methods. Yardley (2000) argues that these criteria should be no less exacting than those applied to quantitative studies, and proposes four principles which can be used as a guide to the quality of a qualitative study: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. These cover both the manner in which research is carried out, and the quality of the interpretations that emerge from the work. These two aspects also highlighted by Stiles (1999) and are aspects which could be seen to mirror the dual focus on process and content which characterises psychotherapeutic work.

This study has sought to address Yardley's (2000) criteria in a number of ways. Firstly, sensitivity to context has been has been attended to by a detailed examination of existing literature on the topic. It has attempted to be explicit about the rationale behind this research (see below in personal reflexivity), and about the epistemological position taken by this researcher. The methodology has been examined in detail and supported by an explanation of how it upholds this research's commitment to a subjective position. Similarly, this study has focused on recruiting participants who have the experience necessary to provide the perspective that this research is aiming to explore (see inclusion and exclusion criteria below) and care has been taken throughout the analysis to ground findings in the data provided by these participants, as evidenced by verbatim extracts throughout.

In a similar way, this research has attempted to demonstrate its commitment and rigour throughout the study. This is demonstrated by the efforts taken to ensure that these participants are appropriate for this study (see inclusion and exclusion criteria) while ensuring that they were treated ethically and fairly (this is discussed in the ethics section below). This included sending participants copies of their transcripts and inviting them to check them for accuracy (see data analysis below), and submitting one transcript for an validity check by an independent researcher (again, please see data analysis). Further, this section provides a detailed description of how the analysis was carried out, and throughout the analysis section the write up of the results aims to demonstrate its rigour by the depth at which the data was engaged with, and the care taken to ensure interpretations are grounded in the data.

In order to comply with Yardley's (2000) transparency criteria, efforts have been made throughout to provide detailed and logical explanations of decisions made, samples included and methodological processes. To this end, a sample transcript is provided in the appendices, along with the table of themes that emerged from this transcript. Both are from the same participant to enable the reader to track how the initial analysis was abstracted up to form master themes for this participant. On a wider, more philosophical level, care has been taken to adequately describe how this researcher interpreted the fit between the research method chosen and its coherence with both the aims of this study and her position as a trainee counselling psychologist.

Finally, the themes that appear to have emerged from this analysis are examined in the context of existing research and discussed with reference to their potential implications for counselling psychology. Thus, the research aims to adhere to Yardley's (2000) fourth and final principle of discussing the impact and importance of a piece of research. This study has taken a subjective and contextual focus which it understands will not conform to some people's ideas of what constitutes valid research. However, it has endeavoured to remain committed to this position throughout and hopes and believes that in maintaining this epistemological coherence it has demonstrated its validity. The extent to which this research succeeds in its commitment to the above principles of validity and quality will ultimately be for the reader to decide.

4.5 Participants

4.5.1 Sample size

The idiographic nature of IPA means that the approach focuses on the individual and their understanding of a phenomenon. The approach is designed to try and elicit the richest and most detailed descriptions from participants and the subsequent depth of analysis of these descriptions means that the sample size is limited (Smith, Flowers & Larkin, 2009). This allows the research to talk about these participants in detail, exploring the convergence and divergences of their experiences rather than make more general claims (Smith & Osborn, 2008). Smith, Flowers and Larkin (2009) propose between three and six participants as a suitable number for a student led IPA research project. Smith and Osborn (2007) use six participants in their analysis of the psychological impact of chronic lower back pain, and other IPA studies such as Rizq (2011), Arroll and Senior (2008), Shaw, Senior, Peel, Cooke and Donnelly (2008), and Eatough, Smith and Shaw (2008) have used between five and eight participants. There are instances of IPA being used for both individual case studies (Eatough & Smith, 2006), and with slightly larger numbers, such as the fourteen participants included in Dickson, Knussen and Flowers's (2008) study. However, the norm seems to average between five and eight as recommended by Smith et al. This study used six participants in keeping with these recommendations and falling within the average number for an IPA study. This was a small enough number to allow for adequate depth of analysis, while still large enough to allow scope for a cross case analysis to examine convergences and divergences between accounts.

4.5.2 Recruitment

4.5.2.1 Combat Stress

Combat Stress is the UK's leading military charity specialising in the care of veterans' mental health. It was founded in 1919 with the aim of helping the recuperation of soldiers from the First World War who were suffering from shell-shock. It now manages a caseload of over 4,400 veterans through its outreach programme and at three residential centres: Tyrwhitt House in Surrey, Audley Court in Shropshire and Hollybush House in Ayrshire[1].

[1] For more information please see the Combat Stress website www.combatstress.org.uk

I first contacted Combat Stress in October 2008 and spoke to Dr Imogen Sturgeon-Clegg, a Chartered counselling psychologist at Combat Stress. She agreed in principle that Combat Stress would be able to help with my research in terms of providing participants, and that she would act as my external supervisor for the project. This was formally agreed the following year and ethical approval was achieved through completion of the Ex-Services Mental Welfare Society (Combat Stress) ethics form (appendix 8.1) which included copies of all documentation relating to the study such as the recruitment poster and the participant information form. Ethical permission was gained with the proviso that no veterans in their first week would be interviewed, and that a criminal records check was completed (appendix 8.2). This was duly carried out through the Soldiers, Sailors, Airmen and Families Association (SSAFA) and passed in July 2010 (appendix 8.3)

Veterans arrive at Combat Stress with a range of previous therapeutic experience, from none at all to several years. The model of therapy at Combat Stress is varied, involving art, group, and individual therapy, group workshops, home visits and so on. It is also long term; contracts are open ended and veterans visit a Combat Stress centre one to three times a year for a two week period. When not at Combat Stress, veterans have a variety of structures in place at home for their support. These vary widely and as no specific information was requested on this, any evidence in this study is anecdotal.

4.5.2.2 Recruitment Procedure

Participants were recruited using advertising placed around Combat Stress residential centres to ensure that participation was voluntary (appendix 8.4). Advertising was designed to fully outline what participation would involve, including: emphasis that there was no compulsion to take part; that participation or non-participation would in no way affect the services received from Combat Stress; the nature and topic of the interview; the audio recording and transcribing of the interview; and issues around confidentiality and anonymity.

Participants volunteered in two ways. Either they contacted the researcher directly using the contact information provided, or they spoke to staff at Combat Stress who would pass their name and contact information to the researcher. Telephone interviews were conducted with each participant to ensure that they were clear on what would be involved in order to begin the process of gaining fully informed consent, and that they matched the inclusion criteria for the study. If this was the case, and the participant was still willing to take part, a date and time was set up for the interview.

All interviews took place at one of Combat Stress's residential centres, for ethical reasons which are outlined below.

4.5.2.3 Inclusion and Exclusion Criteria

According to the principles of IPA, participants are recruited on the basis of their expertise on the phenomenon being studied and therefore form a relatively homogenous group; they can all grant access to a particular perspective (Reid, Flowers & Larkin, 2005; Smith, Flowers & Larkin, 2009). As random sampling cannot achieve this, purposive sampling is used and participants were recruited on the basis of their both:

a) Having served in a combat role for HM Armed Forces. The Merchant Navy is counted as part of the Armed Forces when it is acting in support of the Royal Navy during a period of active service. As the UK Armed Forces do not allow women to serve in combat units, this meant the sample would be limited to men.
b) Having since left the Armed Forces, and been diagnosed with PTSD by a Combat Stress psychiatrist.

For the purposes of this study the Ministry of Defence definition[2] of the word veteran was used, in which a veteran is anyone who has served in the Armed Forces for any length of time.

Eleven veterans responded, and five were subsequently excluded from the study. The first was in his first week at Combat Stress which excluded him from the study according to the criteria set by the Ex-Services Mental Welfare Society ethics committee (as above, see appendix 8.1). However, he was keen to participate so an interview was carried out on the understanding that this would be a pilot interview and the contents not analysed for inclusion in the research. This interview is discussed in greater depth in the methodological reflexivity section below. Two were excluded as their PTSD was the result of incidents which had not happened during active service. One was excluded because he was no longer resident at a Combat Stress centre so this would have been incongruent with the ethical foundations of the study (please see below). A final participant started an interview but found it too distressing to continue and asked to withdraw. The recording was subsequently deleted and his paperwork was securely destroyed.

[2] www.mod.uk/DefenceInternet/DefenceFor/Veterans/

Six veterans, therefore, are included in this study (see Table 1 for information on these participants). As Table 1 shows, there is a large variety in the number of years of experience that these participants have of therapy. The possible impact of this on the findings is explored further in the discussion.

Table 1. List of participants and demographic information

Name	Age	Branch of Service	Duration of service (years)	Rank on discharge	Date of discharge	Date of diagnosis	Years of therapy
Max[3]	48	Merchant Navy	5.5	Acting Chief Petty Officer	1985	2007	3.5
Pat	57	Army	12	Lance Corporal	1984	2006	5
Ralf	47	Army	25	Sergeant	2006	1991	20
Rob	50	Army	7.5	Lance Corporal	1985	2008	3
Sam	57	Army, Navy & Air Force	23	Warrant Officer	1993	2009	3
Tom	58	Army	13	Sergeant	1981	2000	11

4.6 Data collection

4.6.1 Semi-structured interviews

Kvale (1996) describes a semi-structured interview as a professional conversation 'whose purpose is to obtain descriptions of the life world of the interviewee with respect to interpreting the meaning of the described phenomenon' (p. 5). Although IPA does not specify that semi-structured interviews are the only way of collecting data for analysis, they are the exemplar because, as Kvale's description illustrates, they allow data to be collected in a manner which is commensurate with the philosophy of IPA.

[3] Please note all names have been changed to protect confidentiality

Firstly, they offer the space for participants to be able to speak in their own way and using their own words. This feature also allows the researcher to follow leads that arise in the moment (Smith, 2004) and modify questions as the interview progresses (Smith & Osborn, 2008). A provisional interview schedule was created (appendix 8.5) but as the aim of the study was to gain the perspective of the participants as far as this is possible, this served as a guide only and was adapted during each interview according to what happened in the moment. Questions were open ended and non-directive, and only became more focused to encourage the participant to give more detail or to check an understanding (Willig, 2001). In order to avoid imposition of psychological meanings and interpretations, 'therapy' was left deliberately undefined so that definition of therapy according to each participant could emerge.

4.6.2 Interview procedure

Before the start of each interview, participants were provided with a briefing form (appendix 8.6) outlining the aims of the study. This also covered issues of anonymity and confidentiality, and the audio recording of the interview. The interview began only once these issues had been discussed in full with the participant and they had signed a consent form acknowledging this, and their continued willingness to participate (appendix 8.7). Participants were also asked to complete a brief demographics form (appendix 8.8).

Each interview lasted roughly one hour. On completion, participants were provided with a debriefing form (appendix 8.9) including more a detailed description of the aims of the study and contact information should they require further information or would like to withdraw. As all participants were resident at a Combat Stress facility during the interview, they had access to twenty-four hour physical and mental healthcare should the interview raise any issues which either caused them distress or they wished to discuss further.

4.7 Ethics

4.7.1 Ethical considerations and approval

Ethical considerations were grouped under two main categories: responsibility for the physical safety of participants, and responsibility to ensure that their interests and well-being were of primary importance.

On this basis, ethical permission was sought and awarded from two bodies. Firstly, the Roehampton University Ethics Committee to whom an ethics application from was submitted (appendix 8.10), along with all forms relevant to the study (as outlined above) and a risk assessment (appendix 8.11). Ethical approval was granted, subject to certain amendments to the application, and the proviso that approval was also given by Combat Stress (appendix 8.12). Ethical permission was subsequently sought from Ex-Services Mental Welfare Society (Combat Stress), the conditions of which are outlined above.

4.7.2 Distress

The main ethical concern for this study was that the interview process could raise issues which might cause the participants psychological distress. Despite the care and attention taken to ensure that risks are kept to a minimum, however, it was impossible to guarantee that the participants would feel no distress as a result of taking part in research. The possibility of the need to manage this distress during the interview process was considered at length before the interviews began. This would be a challenge, both from the point of view of the researcher trying to keep the interview on track, but also from the point of view of a counselling psychologist who can empathise with the cost of exploring difficult memories and experiences. It was impossible to prepare for this fully but it was vital that it was handled sensitively, using empathic and non-judgemental responses to provide a safe and holding environment for the participant.

The following sections outline the measures taken to ensure that the risk of distress was kept to a minimum. Some of these measures have been discussed above so are simply touched on here and the reader is referred back to the relevant section for a more detailed explanation.

4.7.2.1 Informed consent

Measures taken to ensure that participants were fully informed about what participation would involve are outlined in the section above describing recruitment procedure. Stress was also placed on the participants' right to withdraw at any time without recrimination or demands for an explanation by the researcher.

4.7.2.2 Confidentiality and anonymity

For the purposes of this research there were two sides to the issues of anonymity. In so far as it refers to the confidentiality of the content of interviews, this was ensured as far as possible through following strict procedures. Data was stored to ensure that only the researcher had access. Electronic copies of audio recordings, electronic transcript, notes and analysis were kept on a password secured personal computer kept at the researcher's home. Any identifying information was removed from transcripts, notes and analysis. Hard copies of the interviews were identified only by a pseudonym and were kept in locked cabinet, separate from participant ID forms. All ID numbers were listed on participants' debriefing form to be quoted if they wished to withdraw from the study.

Anonymity in terms of participation in the study to other residents of Combat Stress was more complicated. For the convenience and support of participants, all interviews took place at the residential centre at which they were staying. Recruitment posters around Combat Stress centres meant that both staff and residents could have been aware of the research. Should a participant be seen with the researcher, it was reasonable for them to assume they were participating, thus compromising their anonymity. As there was no way to avoid this, participants were warned during the telephone interview that this was a risk. In practice, this did not seem to be an issue for participants. None of them declined to take part on the basis that this anonymity could not be guaranteed, and some even commented that they had mentioned taking part to other residents.

4.7.2.3 Location of interviews

Interviews were carried out at a Combat Stress residential centre for ethical reasons which are outlined above in the sections on Combat Stress and interview procedure. Additionally, interviews were organised to be at a time convenient to each participant individually, ensuring that it did not interrupt their usual timetable while at the centre.

4.8 Data analysis

IPA does not prescribe a set method for analysing data and maintains a commitment to flexibility and creativity in this process (Smith, Flowers & Larkin, 2009). Analysis is a personal process, involving the researcher's subjectivity at each stage (Smith & Osborn, 2008). Having said this, a number of guidelines are available which have in common a series of processes which are designed to access what is at the core of IPA's interest - the meaning-making in which the participants engage in order to make sense of their experiences. This begins with an individual case-by-case analysis and moves on to a comparison across cases.

In this study, data was transcribed verbatim from the taped interviews. As part of this research's commitment to Yardley's (2000) principles of rigour and transparency, four participants were then sent a copy of their transcript and were invited to check their accuracy, add comments or delete any information they felt necessary to maintain confidentiality. Two participants had specified that they did not want to see their transcript. Only one participant requested changes and these were duly made.

The transcripts were then read repeatedly to allow the researcher to become familiar with the material. Initial notes were made down the right hand margin, commenting on anything that stood out for the researcher. This included words and phrases that seemed significant, repetition, use of metaphors, even random, seemingly unrelated ideas that occurred during the reading. This kind of noting increases the depth at which the researcher knows the text, and also helps think about the way in which the participant speaks about, thinks about and understands the issues in question (Smith, Flowers & Larkin, 2009).

At this stage an additional validity check was carried out by an independent researcher not linked with the study. They conducted their own initial noting or first stage of analysis on one of the transcripts in order to generate ideas for comparison with the researcher's own analysis, ensure that the researcher's perspective was credible and identify themes the researcher might have missed (Yardley, 2008).

Following this, the left hand margin of the transcript was used to make more abstract, thematic notes based upon the observations made during initial noting. The aim of this was to reduce the volume of notations, while maintaining the complexity of the account, identifying connections across the whole of the transcript and looking for patterns in the exploratory notes (see appendix 8.13). These themes were then listed separately and connections between them identified. Clusters were arranged together under a superordinate or master theme, such as 'being misunderstood'. Checks were made to ensure that these themes had retained their connection with the original text, i.e. that they were grounded in the participant's account (Smith, Jarman & Osborn, 1999). Quotes were used as identifiers to aid this process (see appendix 8.14).

Following this process, the master themes for each participant were brought together to continue the analysis across cases and to look for convergences and divergences between cases. Superordinate themes were adapted and developed to reflect the experiences of all participants and again, quotes were used to help maintain the commitment to the participants' accounts. Finally, during the writing up, this process of abstraction and interpretation was continued, with the exploration of accounts and interpretation by the researcher as to possible meanings and explanations, as will be seen in the following section.

4.9 Personal reflexivity

Willig (2001) argues that qualitative research includes two separate forms of reflexivity, epistemological and personal. Epistemological reflexivity is concerned with the way the study has been set up and carried out, and what differences might have been found had this been done in a different way. The decisions behind the epistemological foundations of this research are outlined and evidenced above, and their impact will be explored and assessed continuously throughout this study, but particularly in the discussion.

Personal reflexivity, on the other hand, is concerned with how far the researcher's own person, their values, history, beliefs and experiences may have shaped the research and in turn, been affected by the research and as such, forms an equally important pillar of qualitative research. To this end, I have explored here my personal interest in this area of research.

My interest in military history began at primary school, aged ten, during a class project on the Second World War. With the possibility of boarding school approaching in the next couple of years, I was struck by the experience of evacuees being sent away from home, albeit for very different reasons. This started a long standing interest in the reality of war and its impact. Childhood books *The Silver Sword* by Ian Serraillier and *The Children of the New Forest* by Captain Marryat graduated into early school set texts including *Goodnight Mister Tom* by Michelle Magorian, *Carrie's War* by Nina Bawden and later, the poetry of Owen and Sassoon from the First World War. Eventually, I chose to complete my A' level history dissertation on the Crimean War of 1854-1856. As I got older and my understanding grew more sophisticated, I lost an idealistic impression of war as a time of heroics, courage, even glamour. While heroics undoubtedly happen, I came to understand that they are the exception rather than a norm during a time that is really about perseverance, struggle, death, often filth and exhaustion. War might bring out the best in people, but it also brings out the worst.

Increasingly my reading came to focus on the personal amongst the bigger picture of generals, politics, campaign aims, developing weaponry and troop movements. What was it like to be a private soldier during Marlborough's Battle of Blenheim in 1704? And how was this different during Wellington's peninsular campaign in the early 1800s? Or at the Battle of Arnhem in 1944? When I think about what this research area means for me it is something about this – the experience of the common soldier for whom war is not something to read about in a book, but who has to test themselves against it, live through it, and historically, often not by choice.

War for the UK in the 21st century is a different beast. Conscription is gone, but so has some of the historic regimental identity in the Labour party reforms of 2006 and 2007 (Mallinson, 2009). My understanding too is still changing. Long after my research proposal and title for this study had been approved I attended an NHS Tavistock and Portman trust conference entitled 'After the war is over: working with ex-military personnel'. Here I came to understand that even the word 'veteran' has different meanings for different people.

I started to think about the impact of myself as both a civilian and a female. Lyons (2007) talks about the concern in qualitative research with representing the other: how to ensure an accurate portrayal, to balance what is being heard and interpreted with an understanding of the researcher's own subjectivity; how to hear difference, especially if they are a group which has previously had little opportunity to make themselves heard. As a female and a civilian I have never had experiences even remotely like those I have heard about from my participants, but I do have my own understanding and imagination of war. I have never had PTSD, but I have had over four years of personal therapy. Despite this, would it be possible for male combat veterans to trust a female civilian to tell their story? And given the demographic differences, would I be able to?

Coyle (2007) points out that while making what he terms a researcher's 'speaking position' (p. 18) clear is one step, it is too easy to miss out the relevance this has for the research. How does a speaking position influence the research process and product? I have endeavoured to bear this in mind throughout this piece of work, and discuss it where relevant.

4.10 Methodological reflexivity

The role of the researcher and their subjectivity is a continuous influence throughout a piece of research, and this is no different methodologically than it is epistemologically or personally. Thus, there is a third form of reflexivity to be considered - methodological reflexivity.

A piece of research is planned over years, and it can therefore seem like an impossible task to distance yourself from the weight of that history when sitting with a participant at the interview stage. Indeed, the epistemological position taken in this research would argue that it is impossible to bracket this off. Instead, therefore, in order to honour the time and trust that each participant has invested, it was important to examine my own expectations to access an idea of the lens through which I approached the data (Hoyt and Bhati, 2007).

4.10.1 Interview of my assumptions

To this end, before carrying out the first research interview I asked a colleague to interview me using my own interview schedule. The aim was to make explicit what I expected to hear from my participants, with the understanding that these expectations would mirror what I wanted to hear. I hoped that in being conscious of what I was looking for I could better avoid unconsciously prompting my participants, or following avenues which matched what I was interested in at the expense of what they wanted to say.

In addition to confirming some of my expectations, such as my assumption of the importance of therapy, the interview also raised two significant and previously unconscious expectations. Firstly, that my interest in their experience of therapy was premised on the assumption that this therapy would be dealing solely with the experience and aftermath of their service careers. Even more specifically, that it would be concerned with their experiences of combat. I had allowed the inclusion criteria I set to make this a homogenous sample to creep into my expectations about their lives, as if their experiences were limited to those I wanted to hear about. I had not considered the potential impact of other life events, both pre and post deployment which might be raised in therapy and impact upon how it is perceived.

Secondly, this interview created a greater awareness of the strength of my personal bias towards therapy, and my expectation and desire that it would have proved helpful to my participants. I had deliberately not specified the type, length or theoretical model of therapy experienced with the hope they would then be able to volunteer their experiences of therapy as they understood it, rather than imposing a psychological understanding. Despite this, the interview raised two concerns. Firstly, I was aware of the possibility that I would unconsciously communicate that I did not wish to hear negative opinions or experiences of therapy which would make it difficult, uncomfortable or even impossible for these participants to communicate them. Secondly, that my status as a trainee counselling psychologist would cause the same difficultly, namely that it would be hard to express any negativity. As a result, these concerns were at the forefront of my mind during the interviews although in practice they did not seem to be a concern for the participants, as is demonstrated by the variety of therapeutic experiences outlined below.

4.10.2 Pilot interview

To continue the process of making my own assumptions explicit, a pilot interview was also carried out (as above) with a volunteer who wished to contribute but was excluded for ethical reasons outlined by Combat Stress's permission to carry out the study. This was an opportunity to try out the interview schedule, see how it worked in practice and what, if anything needed to be changed. It was also a chance for me to get used to the distinction between being a trainee therapist, which was very familiar, to being a research interviewer, which was new.

This turned out to be an invaluable process, especially in terms of my role as interviewer. The schedule proved to be a useful memory aide, although many of the questions came up naturally during the course of the interview. Learning the schedule beforehand was helpful as it allowed a mental ticking off of topics as they were covered rather than constantly referring to the list. The loss of this structure however made it much harder to funnel the interview down to get into more depth and detail. Added to which, it came as a surprise to realise that the volunteer had a schedule or agenda of his own. His anger about the therapeutic services provided by the Armed Forces dominated the interview, and it was a lesson that at times I would need to provide much more structure if the interviews were going to stay roughly on the subject matter.

5. Analysis

5.1 Introduction

The following is an understanding of how six veterans diagnosed with combat-related PTSD experience therapy. Two master themes emerged from the IPA analysis of their interviews: 'being misunderstood' and 'developing understanding'. These themes are represented in Table 2 along with their related subthemes.

Table 2 Master themes and subthemes

Master theme 1	*Master theme 2*
Being misunderstood	**Developing understanding**
Subtheme 1: 'What's wrong with me?': Misunderstanding themselves	*Subtheme 1:* 'You've got to give your heart and soul to it': From resistance to engagement
Subtheme 2: 'As much use as a chocolate fireguard': Being misunderstood by civilian society	*Subtheme 2:* 'Being myself, no mask': Enabling self-awareness and self-expression
Subtheme 3: 'We just weren't looked after one bit': Being misunderstood by the Armed Forces[4]	*Subtheme 3:* 'This is our new regiment': Being understood at Combat Stress.

The first master theme, 'being misunderstood' approaches the experience of therapy indirectly, throwing it into relief against the backdrop of the confusion and misunderstanding that appears to precede it. The participants describe both an internal confusion and an external struggle to be understood by others and be given the help and recognition that they would like.

[4] All but one of these participants served in the Army, at least for the majority of their career, so there is a preponderance of references to the Army and soldiers. This is not to disregard or place less importance of the experiences of Max or the Merchant Navy in which he served, simply a reflection of this sample.

The second master theme, 'developing understanding', engages with the therapeutic experience more directly, charting these participants' experiences of a gradual increase in their commitment to therapy and their developing relationships with both the therapist and themselves. Finally, this second master theme explores the normative experience of being in safe environment with others who have had similar experiences.

Thus, these themes represent an illustration of both the direct experience of therapy and its place within the wider context of their lives – the circumstances under which they came to need and want therapeutic help, and their experience of finding it. This is not an exhaustive account of all the data gathered in the research interviews, but an interpretative understanding developed to answer the research question posed by this study about how these veterans experience therapy. As such, this is just one interpretation of the data and a different researcher may have produced a different account. This chapter will explore this interpretation in depth, and some of these themes will then be discussed with reference to the extant literature in the next section.

5.2 Master theme 1: Being misunderstood

The first master theme consists of the three subthemes: misunderstanding themselves; being misunderstood by civilian society; and being misunderstood by the Armed Forces. Together, these subthemes explore the period between the time when these participants first realised that something was wrong, that their behaviour was changing, and when they finally found help. The first subtheme casts light into the depth of the confusion experienced by these participants in relation to what was happening to them and the challenge to their military identity presented by fact of their civilian status. This internal struggle is mirrored by the second subtheme which explores the external sense of isolation engendered by the difficulties of reacquainting themselves to a civilian world. This includes both relating to civilians and in navigating the NHS to acquire the help needed. Finally, the third subtheme highlights the way in which the gulf these participants perceive between themselves and the civilian world is compounded by their sense that they were abandoned by the Armed Forces and left to cope alone with the consequences of their military careers.

5.2.1 Subtheme 1:

'What's wrong with me?': Misunderstanding themselves

It is Pat who asks above 'what's wrong with me?' and his question reflects the experience of all of these participants, bar Tom, who report a long period during which they had little or no understanding of mental health problems in general, let alone the specific nature of PTSD and its symptomatology. In the absence of the explanations that some knowledge of this area would have provided, these veterans provide their own explanations, attributing their symptoms to a number of other causes, as demonstrated by Max below:

> *I was waking up in the middle of the night, absolutely pouring with sweat and it sort of – my pillow was soaking and I was turning it over to get the dry bit, and I was putting it down to the fact that I had the wrong quilt cover on* (89)[5].

There is something immeasurably sad about Max's sense making of his night-time sweating. The terms 'absolutely pouring' and 'soaking' evoke more of an impression of a deluge of rain than sweating, and his use of them clearly highlights the extent of his problem. The pathos of this is heightened by the gulf between this extreme description of the problem and the mundane, quotidian nature of his explanation – the wrong quilt cover. Max here has attributed the sweating to an external cause and in couching his issue in this way he has ensured that he retains control over the solution. In turning over his pillow to get to the dry bit, however, it could be interpreted that Max is unwittingly avoiding the problem – although his solution might provide temporary relief, he could be seen to be literally turning his face away from the problem.

Max here does not understand the change that has taken place in himself but he does recognise that this change has occurred. In contrast, Sam's experience was that everything, or specifically he, was the same as he always has been:

[5] Line numbers refer to the line on which the quote starts. [Text] indicates where text has been edited. All quotes have had repeated words and place holder sounds such as ums and ahs removed for ease of reading, unless they add to the sense of the quotations.

> *I thought I was just a normal person, bringing up a family […] and somebody said to me "when you get hyped or when something really annoys you or something, you're like Jekyll and Hyde […] you physically change […] it's frightening" and I thought what the hell? You know, that's me'. And I didn't see it but the more I explored it and people becoming more honest with me, they said 'yeah, one minute you know, you're a pleasant person, and then all of a sudden something happens, you know, first indication is your face, everything just changes and that's…'. And I thought 'oh god' […] You know, I thought I was normal and then all of a sudden people was telling me I wasn't normal. That's how they was putting it. So I thought well 'am I mad? Am I?'* (271).

There are two different perceptions of Sam here. The first is Sam's own in which he is 'normal' and engaged with the usual business of life. This everyday quality to Sam's self-image provides a stark contrast to how others perceive him – as a person who will literally undergo a physical change when annoyed. What is striking here is the depth at which Sam is apparently unaware of the behaviour these people are referring to, to the extent that even once pointed out to him, he cannot see what they mean. Initially Sam is sceptical, asking 'what the hell?' but gradually his sense of self seems to be undermined; he mistrusts his own perception and moves towards putting his faith in others. The destabilising nature of this is evidenced by the circularity of his reasoning: 'I thought I was normal, and then all of a sudden people was telling me I wasn't normal', and his repetition of the word 'normal' could be interpreted as an unwillingness to let go of this definition of himself. Ultimately, then, his final questioning 'am I mad? Am I?' suggests a move towards this new definition, but the repetition seems to sound a note of panic, perhaps casting doubt over his willingness to accept it.

Sam's use of the Jekyll and Hyde metaphor could be interpreted in a number of ways. Firstly, it serves as an illustration of the nature of his behaviour. One interpretation of the Jekyll and Hyde story understands it as a depiction of a split personality, the two dimensions of which operate at opposite ends of the moral spectrum, namely good and evil (Roberts, 2012). If Sam's 'good' side is the one he perceives, this means that the one he could not see would be the 'evil' side. The unspoken question might therefore be about what Sam might be doing when he is not aware that he has 'changed'. In another parallel, according to Stevenson's story, Dr Jekyll initially has to take a potion to act as a catalyst for his change. Later on however, this change happens involuntarily (Roberts, 2012), an idea which echoes Sam's involuntary physical change outlined above.

Other interpretations of this metaphor could interpret the dichotomous nature of the relationship between Jekyll and Hyde not just as a reflection of Sam's behavioural change, but also the two versions or perceptions of Sam's behaviour. Similarly, this dichotomous relationship also appears to mirror Sam's splitting of 'normal' and 'mad', where there is no middle ground, he either has to be one or the other.

With the appearance of this previously unrecognised external self, Sam appears to be reporting an internal perception which does not seem to match the external reality. This mismatch is echoed by the discrepancy reported by these veterans between their new external identity as civilians, and their internal retention of their military identity, as demonstrated by Pat below:

> *And how to get on with the world outside 'cause it's really hard […] you are a civilian, you're not army […] But you are army anyway, 'cause you never get that out of a soldier […] Once you've been in and served you're army – he's civilian, you know. You're ex, he's still civilian. Do you know what I mean? You never become a civilian, because you are army aren't you. That's the way you look at it. No, no no, I'm not a civilian, I'm ex-service…guy so I'm not a civilian and that's the way you work* (609).

Pat's repetition of the word 'civilian' five times here mirrors Sam's repeated use of 'normal' above and suggests a deep rooted confusion about the way things are. The facts say that he is a civilian, simply because he is no longer in the army, but his internal identity is at odds with this. His circular reasoning evokes the image of a labyrinth in which he is caught as he tries to reconcile the external facts ('you are a civilian') with his internal reality ('you never get that out of a soldier'). Perhaps his use here of the second and third person pronouns 'you are' and 'he is' as opposed to first person is a way of distancing himself from this dilemma, but ultimately appears to be futile as finally he moves towards acceptance towards the end of the extract. Under this interpretation, his cry of 'no, no, no' could be understood as a final act of defiance before his switch to first person indicates that he has found a compromise he can live with 'I'm an ex-service…guy so I'm not a civilian.'

Pat's resistance to giving up his status as an army man could be seen as an indication of how deeply ingrained this identity can become over the course of a military career. This idea is dynamically demonstrated by Ralf below, who also goes on to offer an explanation:

> *you could have cut my head off and it would have had 'British Army' written through the fucking rest of my neck […] you know, like Blackpool rock* (448)

and later:

> *you know the biggest problem I have now is that if-if a senior officer walked in here right now I'd give it fucking like that [salutes]. It's inbred in you, you've got to brutalise a serviceman to get him to do what you do, you've got to remodel him or her to go and do what they do. If you don't do that fucking how they ever going to carry your orders out, go do the job you want them to do* (949).

The 'cut my head off' here could be seen to echo the violence of Ralf's military experience and the brutality of 'written through the fucking rest of my neck' creates a stark contrast with the metaphor of a child's holiday treat of Blackpool rock. Yet this metaphor is extremely effective, creating a provocative image of a military identity so driven into the heart and soul of Ralf that it has become part of him and simply cannot be separated out or removed, just as the words Blackpool rock remain legible even after pieces are bitten off.

This is an idea that Ralf himself appears to support as he later identifies his biggest problem as the automatic nature of some of his military responses, seemingly identifying his training as the seed from which this grows. His use of 'inbred' also suggests that that this training process almost creates a different breed of man, and the violence of his earlier quote is echoed here by the role of brutality in the training process; any 'remodel' requires the breaking down of the existing model in order to create the new version. What is left unsaid in this quote is the nature of what this remodelled serviceman might have to do. The first half of Ralf's final sentence 'if you don't do that fucking how they ever going to carry your orders out' seems too extreme to be a reference to run of the mill daily orders. Instead, Ralf appears to be hinting at the scenarios in which obeying orders means risking your life.

Or an even more sinister interpretation could view this as an allusion to the horror of what soldiers might be ordered to do to men fighting on the other side, the enemy. Under these circumstances, in this context, the close association that seems to exist for Ralf between violence or brutality and his military identity begins to make sense.

Tom, however, presents a different picture of the challenges to self and identity that present themselves on leaving the Armed Forces. Tom is not the only one of these veterans to have a degree, but he is the only one to have a degree in psychology, and experience of working in the NHS. Whether it is this factor that has made Tom's experience so different to the other participants is speculation, but he does seem to have resolved some of the identity issues that others are struggling with:

> *I like the word veteran 'cause we have a group here [at Combat Stress] saying 'you're not in the Forces anymore' – people struggle with that. And I don't see myself as a civilian, but I don't for one minute imagine that I am still in the Army, so veteran fits very comfortably for me* (378)

and later:

> *cause I've got many identities - I'm a father, a friend…I'm a veteran and…I don't-I can't-I don't see myself as a civilian because that experience of being in the army will stay with me until the day I die. Because it's special, it means a lot to me* (391).

In many respects, Tom is exploring the same idea that Pat was talking about above. But while he does recognise the complexity of this issue and the problems it can cause ('people struggle with that'), he does not report struggling himself. Instead, Tom appears to have found a way to fit his service career into the rest of his life. His mention of 'many identities' suggests that his military identity is not all consuming in the same way that it seems to be for Ralf, instead he has amalgamated it into other aspects of his life such as being a father and a friend. His continuous use of the first person and the present tense as he speaks make this seem almost straightforward for him in direct contrast to the quotes for Pat and Ralf presented above; he can acknowledge the importance of his army experience without holding on to it to the exclusion of everything else.

The only indication that this might not always have been the case is his brief search for the right word 'I don't-I can't-I don't' in reference to seeing himself as a civilian. This back and forth in his speech between not wanting and being unable is suggestive of a possible previous struggle with this issue, just a hint that he too might have found the move from military to civilian a complicated one. Alternatively, this could be seen as a slip of the tongue revealing that he does still struggle on some level; similarly to Pat and Ralf, he 'can't' see himself as a civilian, despite his apparent resolution of the issue. However, he tempers this in the extract above and glosses over the issue by reverting back to 'don't'.

If Tom's words are taken as an indication of a struggle here, they are just a hint of the difficulties explored at much greater depth by Max, Sam and Pat and Ralf above. Their words serve as a sharp reminder that in exploring the impact and effect of therapy, something is inevitably asked about the nature of what brought them to therapy. This subtheme shows the complexity and gravity of what these veterans describe experiencing, the extent to which these experiences are unknown and unrecognised, and the confusion and fear that this can create.

5.2.2 Subtheme 2:

'As much use as a chocolate fireguard': Being misunderstood by civilian society

The first subtheme explored these veterans' experiences of not understanding themselves. Here, the context of this misunderstanding is expanded to include their sense of not being understood by civilian society. This appears to occur on a number of levels. Firstly, from civilians themselves who are perceived as being both unwilling and unable to understand the military experiences of veterans. The veterans' military experience seems to exclude them somehow from fitting in and leaves them feeling isolated and alone. This sense is compounded by a second level of misunderstanding reported by these veterans, this time from the organisational context of the NHS and other mental health services. They are seen to be failing to understand and therefore meet their mental health needs as evocatively described by Max's quote in the title above. This is at a GP level, but also underscored by a series of negative experiences with therapists and mental health workers which forms the third level of misunderstanding. Overall then, the sense is created that these men have struggled to readjust to a non-military environment and the people in it, as Sam outlines below:

> *civilian environment is, you know, you're sitting around listening to a bunch of, excuse my French, but tossers, talking about mundane things […] what's the matter with you? You want to hear-to witness and experience what I've really gone through'* (455).

The overall effect of this short extract is a succinct but effective dismissal of civilian problems, where the 'sitting around' is suggestive of a passive group, failing to actively engage with or attempt to solve their issues. Similarly, the phrase 'mundane things' belittles these people's issues, linking them to the ordinary, boring, prosaic or routine; whatever the reality of their problems, Sam has clearly perceived them as unimportant in comparison to his own experiences. Sam's use of the vernacular adds to the impression of his disdain. Ironically, although his apology is polite it does not lessen the effect of his swearing, instead prompting speculation about what words he might have used had he been with other military personnel, rather than with an unknown female civilian researcher. There is irony too in his question 'what's the matter with you?'. On one level he *knows* what the matter is, they have told him, but it is this that has created the problem. His perception is that they have overestimated the seriousness of their issues to such an extent that their overestimation has become the problem – he seems to see the 'matter' with them as their inability to ascertain what is important and what is not.

In this context, his final sentence could be read, not quite as a threat, but certainly as a warning. He starts by saying that they should 'hear' his history, but upgrades this to 'witness' and 'experience' as if hearing was not enough and only through the use of all of their senses they could possibly begin to understand what he has been through. He seems to be implying that if they did hear what he has gone through they would be shocked, their priorities might be realigned, and they would realise what real problems are.

Sam's perception, however, is that civilians do not want to hear his experiences. Just a little later he adds:

> *Civilians […] don't understand and they don't want to hear about your stories […] And they think that you're a killing machine. You know, I'm not a killing machine, I'm a human being, trying to protect. And I'm doing it because I like you, I don't know you, but I like you and I want to protect you, your family, my family, the country and what it's worth. They don't want to know and that's where it gets, where we get a bit offended by it* (503).

Here his earlier scorn appears to have morphed into real sadness. Not only does he feel that they do not understand, but they also do not want to hear, they are not interested. There is a dramatic contrast between their perceptions of someone who has been in the Armed Forces, 'a killing machine', compared with Sam's protest of 'I'm a human being'. The use of the word machine here, twice, suggests that the humanity has been emptied out of Sam and he is left as a robot whose only function is killing. But this description of him is belied by his next words where he deals with value-laden concepts such as loyalty, commitment, family, the imagined other and even patriotism. The end result is that they are 'missing' each other on many levels.

The result of this, for Rob, is a sense of terrible isolation:

> *that's what they call it 'the invisible illness' […] nobody knows what's going on in my head, nobody knows what I go through at night, nobody knows what I'm thinking of doing to somebody or doing to myself […] I think I'm, I am sort of very lucky in a way in that I can, just at the last minute sort of think 'well if I actually do something silly' and I-and I've come very close to it and I've even cut myself, and I've sat in my car at 2/3 o'clock in the morning, down a dark lane, with all my medication thinking 'I can't go on like this, despite all this therapy […] It's like-it's like if you're driving down the road, we're all taking in same sort of things, well I suppose […]we are all seeing sort of different things…but I've got another thing running alongside of me and it's Northern Ireland, Northern Ireland, Northern Ireland all the time* (477).

Rob's 'invisible illness' here is a reference to the difference between physical ill health which can frequently be seen and mental ill health which cannot. But it also sets the tone for what becomes an evocative description of a life in which Rob too could be seen to have become invisible. 'Nobody knows' is repeated three times, each time becoming more bleak before finally culminating in what could be read as a thinly veiled threat to harm himself or someone else. His use of 'lucky' so soon after this threat causes a jolt of shock, provoking questions about what could be considered lucky about what he is describing. The fact that this sentence peters out and appears to change meaning half way through, instead becoming about times when he has seriously contemplated suicide, underscores the fact that in reality he does not seem to have been very lucky.

This gains increasing clarity as he explores further what he means by harming himself and his suicidal ideation; moments of metaphorical darkness or desperation ('I can't go on like this') in the reality of the 'dark lane' in the middle of the night. He ends with a metaphor which further highlights his isolation by describing the 'view' that no one else can see. For him, though, it is always there, as a monkey on his shoulder or the perpetual demon on his back.

Rob is not the only veteran to describe such as sense of isolation and for many of them, the isolation is exacerbated by experiences where the NHS and other mental health services have failed to adequately diagnose or treat the mental health problems with which they are struggling and which they did not themselves fully understand. Ralf below highlights how easily these men are excluded from the therapeutic process, even when the diagnosis itself is accurate:

> *I didn't understand it […] I didn't understand what this fucking language was, thinking I was going mad'* (483)

and later:

> *When I first came here, I've still got the records [the psychiatrist] give me four sentences / a paragraph and whole of that was 'this man's got PTSD'. He couldn't even be arsed saying post-traumatic stress disorder. He put in on there. Now that's great if you understand what PTSD is, but if you don't understand what PTSD is someone's going to be going 'per ter ser der' what the fucking hell is that then?'* (861).

Ralf is making a point here about the idiosyncratic nature of the language of mental health care. It can be too easy for professionals to forget how impenetrable it can be to others and Ralf's repetition of 'I didn't understand it' is evocative of his frustrated efforts to make someone explain to him what was going on. This frustration is underscored by his use of 'per, ter, ser, der', sounds which echo those made by a child learning to read. In many respects this situation could be seen to have infantilised Ralf, he is powerless on his own, reliant on others for information and explanation and consequently treatment too. He can do nothing alone while this situation continues – he is as helpless as a child. In stark contrast is his very adult anger about this, demonstrated by 'what the fucking hell is that then?'

Ralf's experience here echoes Sam's reflections above about the experience of others not wanting or bothering to hear what these men would like to say. 'Couldn't be arsed' is a provocative summation of this perception of lack of interest, lack of effort and even dismissiveness. But there is an underlying sadness here too ('thinking I was going mad') that this psychiatrist has not seen it as important to explain. It is difficult not to wonder about what else an explanation might have achieved; the time taken to give it could have acknowledged Ralf's suffering as well as conveyed concern for his well-being. It might also have denoted the psychiatrist's respect for Ralf, Ralf's equal if not primary role in his own recovery, and his ability to take on and process information about his own diagnosis.

There are moments of light however, amongst this darker picture. The following story is Rob's and describes what happened when he had a panic attack on the drive home from Combat Stress and had to pull onto the hard shoulder of the motorway:

> *I was shaking, I was sweating, I was crying. Next thing you know […] policeman. 'You alright sir?' I went 'yeah, yeah, I'm just having a bit of a panic attack'. He went 'right, stay there'. He went back to his car, said something to the guy in the car with him, next thing you know, he gets in the passenger seat. He says 'right, drive down to the service station, down here on the hard shoulder'. So we drove into the service station, he took me inside, and he bought me coffee […] he says he was an ex-serviceman, and he'd seen, 'cause I had all my stickers and everything for Combat Stress on the side, so he knew I'd been […] and it was just a pleasure to, sort of, sit with this guy […] And then I just got in my car and drove home* (527).

Rob's description of himself as shaking, sweating and crying gives a sense of how overwhelming this kind of panic attack can be; his repeated syntax builds momentum in the same way that a panic attack might be considered to gain momentum, gradually becoming out of control. This sense of building tension means that the policeman's arrival can initially be interpreted as having the potential for further negativity; it is not immediately clear whether he is friend or foe. The eventual resolving of him as a kind and helpful figure then has added impact and relief and effectively punctures the atmosphere of building panic.

This story serves as an example of the difference that even a stranger can make and offers a contrast to the negative and isolating experiences of Sam and Ralf above, and even Rob's own experiences which have not always been as positive as this was. In one respect, however, it could be argued that this is not a moment of understanding by a member of a civilian population. This policeman has also been a serviceman; he too has therefore made a transition from military to ex-military and could therefore be considered as part of their group.

There is a sense then that this group are excluded somehow from the rest of civilian society on what could be seen as a reciprocal basis. What emerges from their reports is a form of mutual disdain for the other; different set of priorities or perception of what is important, underlined by a sense that civilians are not interested in hearing about they have to say. This creates a feeling of isolation, compounded by the potential to be additionally excluded from their own therapeutic process. Although there are exceptions, as demonstrated by Rob, these accounts could be seen to be painting a picture of a gulf between the two worlds of military and civilian, which only those civilians with military experience can be seen to bridge.

5.2.3 Subtheme 3:

'We just weren't looked after one bit': Being misunderstood by the Armed Forces

The final subtheme for this master theme explores how these veterans report their sense of having been abandoned by the Armed Forces, their feeling that the military did not understand what they were going through, or were not interested in understanding or helping. For Ralf, this process started while he was still in the Army; he is unique amongst these participants in that he first reported sick while still serving. As a result, Ralf is the only veteran with experience of how the Army deals with the mental health problems of its personnel. The following is Ralf's description of his experience in an army psychiatric unit:

> *I was escorted down there the next day with a guard. They sent me home that night, came and pick me up that-next morning […] they sat me in this corridor I can always remember I walked down there and it were just loads of beds and chairs stacked up in the fucking corridor. The corridor be-the part where he had his office was-all the walls were empty it was like one of them scenes out of er "28 days". And it was just nothing in this whole ward except his office* (335).

The first couple of Ralf's sentences here are marked by his passivity, he is being 'sent', 'escorted', even 'sat'. These are all events that are happening to him and as such he creates the sense that this is all out of his control. In fact, the mention of the guard who escorts him to the ward is more reminiscent of the kind of treatment that a prisoner might expect, rather than a member of staff who has reported sick. This is compounded by his bleak description of the ward – the stacks of beds and chairs imply desertion, or at least a lack of care and attention to the atmosphere of the room. The reference to *28 days* can be read with a number of interpretations. The film is about an alcoholic who attends rehab under court order and only gradually begins to accept that she needs help. Ralf could be understood therefore to share the protagonist's reluctance to undergo treatment and this is reinforced by his negative description of the ward. However, it is possible that Ralf is referring to a film called *28 days later* which depicts the outbreak of a virus which infects and turns most of the population of England into zombies leaving it deserted but for a small band of people fighting for survival. This too fits with Ralf's description above of the isolated, deserted ward and adds to the rather sinister sense of loneliness and abandonment created by the extract above.

Ralf's swearing in the above passage ('fucking corridor') could be read as an indication of his anger about the way the Army treated him. This anger is shown much more clearly in this next extract, also from Ralf, where he outlines the dilemma that the army's treatment of him left him in:

> *[T]he Army knew about combat stress – it'd be quite fucking barking if they didn't allegedly - they just paid lip service to it […] the one thing I can remember from the 1990s and up until 2003 was they paid lip service to it. Yeah so what we've got fucking serviceman with PTSD we're looking after them – they fucking weren't. Right from the late nineties, from about '97, every time I went sick, as in, with PTSD all I was told 'why don't you just get out the Army?' So fucking easy. Why would I want to get out the Army? I fucking loved the Army, it was the Army what was keeping me sane […] what allowed me to still do the job I loved. Which was killing fucking people. How can you not? That – you know, people work in Tescos fucking great, if you like fucking shelf stacking fucking, if it fills your boots, great. If you like killing people, what not better job to go in the Forces?* (760).

Ralf is claiming that despite the Army's claims to the contrary, they knew about but ignored issues with combat stress amongst its personnel. Ralf's experience of simply being told to leave, for example, suggests that the Army worked on the premise that ex-servicemen were no longer considered their responsibility, and therefore encouraged unwell personnel to leave. There is a kind of dark humour in Ralf's use of 'quite fucking barking' here – as if the Army itself were suffering from the same issues with mental health that they tried to avoid in their servicemen.

But the contradiction described by Ralf between the Army's words and actions is also in evidence in in his own attitude towards the Army. This is the same institution that he scorns for their 'lip service' and even accuses of lying ('they fucking weren't'), that he also 'fucking loved'. His own catch 22 was that the same job which he loved and which he did not want to leave was also responsible for the cause and possibly the perpetuation of his illness. In this light, Ralf's claim that the Army was keeping him sane seems, ironically, lacking basis in fact or reason. Similarly, there is also an inherent contradiction in his claim that he loved killing people, a claim that is belied by the fact that this job made him so unwell that he was unable to continue doing it. His reference to stacking shelves in Tesco only serves to highlight how extreme his own job was in comparison.

Ralf's sense that the Army was lacking in any genuine interest in the mental health of its personnel is echoed by both Pat and Sam. The following is from Pat:

> *Well they train you to kill see, and defend yourself, and protect yourself and you're doing that in civvy street. […] when you're finished duty they don't help you out although you've got PTSD. After the bombing I had in Northern Ireland, I had PTSD, which I didn't know about but I carried on with my service, as a young soldier and I hurt a lot of people...not knowing anything. But the Army at the end of it just booted you out – 'get on with it' […] because I'd finished me service, but they didn't want to know* (36).

Pat here feels more sad than angry in the way that Ralf appears to be. He points to a number of areas in which it feels like the Army have let him down, and there is added piquancy to this because we know from Pat that he was very young when this started, therefore possibly more vulnerable and in need of greater support. But this was not what happened and instead the extract effectively illustrates the Army's failings.

Firstly, in that they appear to have provided no training on leaving the Army in contrast to the detailed training he received on joining when he was taught to kill, defend and protect. Thus, he is left with skills that leave him unsuited to coping in a civilian world. Secondly, that Pat had PTSD while serving but a lack of information meant that he did not realise this, and nor was the problem diagnosed by a professional. This did not just have implications for him but also for people around him who he unwittingly hurt. Finally, Pat's description of his departure from the Army echoes the brutality of the bombing he mentions which occurred during his time in the Army. He does not just leave but is 'booted' out; it appears that as soon as he is no longer useful to them, they are no longer interested in him. This mirrors Ralf's sense that in leaving the military, you are also leaving any chance of being helped by them. There is an irony here that Pat was trained initially to both defend and protect himself by an organisation which valued him highly enough to spend time and money on him. In the end, however, it is this very same organisation which leaves Pat needing protection and defence, and which fails to provide either.

Sam uses practically the same words in describing the end of his own Army career:

> *I just told them to sod off one day and they medically discharged me because I wasn't fit for service any more. So obviously I wasn't going to do it anymore! Anyway, and you know, that's the worst thing you can do in the services is say no* (305)

and later:

> *they kicked me out what do they want to know for? They never did anything for me after I've left so you know, they didn't want to know me* (377).

Sam's extract could be read as containing an element of tit-for-tat, with the Army medically discharging him in retaliation for him telling them to sod off, or for saying no. What is unsaid here is what he might have said yes to in the past in order to comply with this ethos of 'can-do'. It is his reference to being 'kicked out' which echoes Pat's description above, and there is another similarity in Sam's tone of sadness, or perhaps it could even be read as wistfulness. The use of a question in the second quote creates the suggestion that Sam is hoping he will be contradicted, or that someone might have an answer that might mean the Army does want to know.

Ultimately though, his experience is uncannily similar to both Ralf and Pat's, in fact both Pat and Sam use the words 'they didn't want to know'. Sam's experience, however, has an added hint of how personal this is; he does not just feel that they do not want to help, but also that he is being somehow personally rejected too – 'they don't want to know *me*'.

Overall, this final subtheme serves as a sharp contradiction to the ideas explored in the previous subtheme, namely that it is a lack of military experience which makes it difficult to understand the world of the military. The Armed Forces *are* the military, and yet this subtheme demonstrates that their consequent knowledge of the work that its personnel undertakes does not seem to positively impact how they deal with or mediate the possible negative impact of serving. Perhaps then, a tentative conclusion might be that it is not the lack of military experience which makes it hard for civilians to relate to those who do have service careers, but a lack of willingness.

5.3 Master theme 2: Developing understanding

The second master theme, like the first, is made up of three subthemes: from resistance to engagement; enabling self-awareness and self-expression; and being understood at Combat Stress. These subthemes chart the participants' experiences during and as a result of therapy. The first subtheme examines how the veterans report a growing understanding and acceptance of their own role in therapy and in managing their symptoms, the role of the therapist in this and the impact that it has on their outlook for the future. This growing understanding involves a developing self-awareness and increasing ability and willingness to express themselves, issues which are explored in the second subtheme. The third and final subtheme outlines how these veterans experience the impact of a supportive environment, through which normative experiences help them adjust to the reality of civilian life.

5.3.1 Subtheme 1:

'You've got to give your heart and soul to it': From resistance to engagement

Resistance to engagement is a spectrum along which these veterans fall and it refers to their attitude towards and participation in therapy. Sam's quote above, 'you've got to give your heart and soul to it', is a reference to the engagement end of this spectrum. Sam is recognising the importance of his own role in therapy in aiding his recovery. But most of these veterans describe starting from a much more sceptical position; not understanding therapy, or being mistrustful of it. It is only gradually that they seem to have accepted the possible benefits and begin to experience them for themselves, and it appears that their therapists contribute significantly to this development.

Ralf below illustrates the more resistant end of this spectrum, identifying his attitude when he started to receive treatment:

> *My attitude in them days was I have been triggered off, an' I, you know, the-the PTSD had come along, you're the therapist, you fucking put the – you put it back in its fucking box and put it away and I'll just get on with my fucking job because at the moment it's a fucking em-an embotherance. You do your job, you sort me out so I can get on with my job* (608).

The passivity which marked an earlier extract from Ralf is in evidence again here, he 'has been triggered off' with PTSD. In fact, his wording in the middle of his first sentence 'the PTSD had come along' almost seems to personify the PTSD, or casts it in a role of its own; a separate entity with its own habits and patterns and definitively not part of Ralf himself. This divorcing of himself from the condition also means that he is able to divorce himself from the treatment, and he is emphatic here that it is not his responsibility to deal with it. Thus, it is the therapist's job to cure him the same way that a doctor might cure a physical illness with medication. Again, this could be seen as a reflection of Ralf's passivity in the face of his mental health problem, but perhaps also as a measure of his over-simplification of the problem. That PTSD could be put back in a box is an echo of his earlier personification of the condition, but also a reflection of how Ralf might have underestimated the potential seriousness of what he is dealing with.

This is underscored by Ralf's use of 'embotherance', a word of his own making which seems to imply that PTSD is a bother, an irritation rather than anything more serious. Its use suggests that Ralf is trying to downplay the impact or seriousness of PTSD. Ultimately, however, this attitude feels like bravado. Ralf's continuous swearing throughout this extract belies his attempts at downplaying and hints at a real fear underneath it. Perhaps the PTSD is having a larger effect than he would like to explicitly admit to or feels able to cope with.

Moving forward from a position such as Ralf's is seen to be a complicated process, and the role of the therapist in this seems to be crucial, as demonstrated by Pat below. He is exploring the process of opening himself up to therapy and linking it with his therapist:

> *she's constantly pounding at me to get the deep information that I've buried inside of me that I didn't want to come out but needed to come out, you know, um…about my father. I could never speak about my father um…sexually assaulting my daughter, I could never tell anybody, but then I told [therapist's name], and then she kept it going, kept it going, and kept it going and it got deeper, deeper, deeper and then she found out, by me telling her, I used to get beaten, and then it all-the picture comes together, the jigsaw puzzle comes together. And after four years, she's got me, right. I've got it now. I know what the problem was when we first come in, you know. 'Cause you, you don't know, you're like that, like a child, you know, who are you?* (734).

There is an element of physicality to Pat's description here, initially evoked by his use of the verb 'pounding' and then underscored by his repetitions 'deeper, deeper, deeper' and 'kept it going, kept it going, kept it going'. This feels like a depiction of therapy as an active process during which the therapist has to work very hard. This makes sense in the context in which Pat understands his problems as 'deep' and 'buried', and which his therapist could then be seen as having to actively dig them up or uncover them. That the therapist has to work so hard could be argued to be a reflection on Pat's habit of silence and consequent difficulty in speaking about these issues. This can be seen in this extract when he pauses and uses the placeholder 'um' twice in quick succession, both times before revealing some of the issues which he has found it hard to talk about.

But this account also seems to offer gradual indications that this habit is changing, and that he is taking greater ownership of his issues through therapy. For example, in reference to another issue he initially says 'she found out', a phrase from which he has been eliminated and could imply that his therapist found out from another source. But he corrects this almost immediately by adding 'by me telling her'. That he had to add this could be understood as a reflection of Pat's past where it would not have been him sharing the information. Adding it, however, implies that he is gradually becoming more comfortable with sharing information like this. This is reinforced by his revealing a third piece of therapeutic material, that he used to be beaten, this time without pausing or using 'um' beforehand. Arguably, it is also possible to read this developing ownership in his phrase 'she's got me, right. I've got it now'. Here, Pat can be seen almost literally taking over responsibility for himself from his therapist, the transfer from her getting him to 'I've got it'.

'I've got it now' could also be interpreted as a symbolic gesture of Pat's own growing understanding of himself. This is supported by his following sentence in which he describes himself as having been a child in terms of his self-understanding. This is reminiscent of Ralf's evoking of a child-like image above and reinforces this idea that Pat knew very little about himself before therapy. That this situation is finally being resolved is most evocatively described by his jigsaw metaphor, which illuminates the process Pat is undergoing in painstakingly piecing together a picture of his life, gradually working through piece by piece and finding their place within the whole as he makes sense of what has happened to him.

Tom is even more explicit about the role his therapist plays:

> *it's like a collaboration between the two of us 'cause we don't have a psychologist up here and me down there […] they'll try and come across as, you know, I'm the person with the knowledge and the power. She comes across as – well we're in this one together really [..] I wouldn't be able to fault her. She just comes across very human an'…erm…to-very occasionally lets me see that-that she-she's quite human an'…has her own issues as well. She doesn't talk about them specifically but she'd be …you know I have my not so good days and it does come across in the therapy but she is saying… it's part of life, you know, I suffer in-in my way as well and, you know, I have my days for hiding under a duvet and I like that because erm…for me and sometimes I've looked and thought 'it's ok for you, your life's sorted, your life's great'* (274).

The underlying message of this extract is perhaps about how Tom has previously perceived the gap between his life and that of his therapist. The idea that a therapist might have a perfect life could seem far-fetched, but is possibly a greater measure of how Tom has perceived his own life. This idea is reinforced by his phrasing in the first sentence; even in his hypothetical scenario the therapist takes the more positive higher position while Tom would be 'down there'. It is possible that this is a reflection of Tom's previous experience of therapists, hinted at by his words 'they'll try and come across as' and reinforced at the end of his extract by his previous image of therapists as 'sorted' and 'great'.

In contrast, Tom's repetition of 'human' could be interpreted as indicating how important it is to him to feel like he has an equal role in therapy. It is possible that if the therapist does not have all the knowledge and power, that gives Tom a measure of control and agency in his own recovery. Perhaps the value of this for Tom is best gauged by his assertion that 'I wouldn't be able to fault her'. Rather than dent his opinion, the knowledge that his therapist is human and able to be open about her own issues seems to have raised his opinion of her. The message that bad days are 'part of life' not only promotes his sense of equality with her, but allows the work to be collaborative, and normalises Tom's experiences of life as a challenge.

Despite increasing engagement in therapy however, these men also report that this is an on-going struggle, and that despite Ralf's initial hopes that a professional could take care of the problem on his behalf, this is not the reality. Max seems to have grasped this but remains hopeful:

> *they're still messing about with my meds, trying to get a-the correct one. Umm…I'm under no illusion that it's a five minute fix, but er…it's a long tunnel and there's a light at the end of it and hopefully I'll get there, or at least I'll go down trying* (154).

As with Ralf above, there is the possibility here that Max too has a passive attitude, indicated by the reference to the control that others have over his drug regime and possibly the expectation that the 'correct one' will solve the problem. However, here this feels more like an understanding or acknowledgement that the medical component of his treatment is the field of doctors or psychiatrists.

His words do demonstrate, though, that the medical aspect of his treatment is not an exact science and involves experimentation. Underlying this is the risk that comes with trying different drug treatments, attempts that will all affect Max in different ways. He seems resigned to this however, and unlike Ralf above, has no expectation, or 'illusion', that this is a straightforward issue. His reference to the light at the end of a tunnel could be interpreted as a literal representation of the hope that he mentions immediately afterwards, and this is a metaphor that he uses later too, as will be discussed below. His final words can be seen as an indication of his determination, the fighting spirit that might be expected of military personnel. They are also a subtle reminder of his history in the Merchant Navy; the implication is that he will keep trying until his personal ship has sunk.

Max's dedication to his recovery is perhaps the overall message of this subtheme. There is a hopeful element to this; a sense seems to emerge from the accounts in this subtheme that the possibility of moving forward, that progress of some type is not wishful thinking. Through a more active and involved approach and a gradual build-up of therapeutic trust, these men could be seen to be saying that the future is no longer as bleak as the first master theme might have suggested.

5.3.2 Subtheme 2:

'Being myself, no mask': Enabling self-awareness and self-expression

The growing engagement with the therapist and therapy explored above appears to be an iterative process, developing alongside an emergent self-awareness and an increasingly ability and willingness to express this. This subtheme examines the second half of this process and the ways in which these veterans describe and experience it. Tom's quote in the title of this subtheme about being himself is indicative of this process; 'being myself' involves an understanding of who that really is, and the reference to the mask implies that this kind of openness might have been more difficult or complicated in the past.

Self-awareness is described in the accounts as taking a number of forms. Sam's narrative below outlines a very personal, internal self-awareness:

it's a battle in the mind, you know, for me personally. Don't think I'm being a nutter because…I've got three people inside me – they're me, they're not voices, but they're me. There's the pilgrim, there's Joseph, a religious icon, and then there's me. And the three of us get together and we battle it out […] Sometimes there's the fourth one, which is not a very nice guy but it's all one – me, but I know the pilgrim's looking for something, going somewhere, trying to… And there's the – I call it Joseph, well like a Christian or whatever it is, a religious… I focus on that one if I need to be calm and rested, look at things in a new light sort of thing. There's me, which you would never see sometimes, and there's the darker side' (221).

This extract calls to mind Sam's earlier extract in which he compared himself to Jekyll and Hyde. Although above this is discussed in relation to its consideration of a dual personality, there is also an argument that this is overly simplistic and that in reality, people are made up of many personalities (Roberts, n.d.). One interpretation of this extract therefore, could be that it represents this kind of multi-way split, and that Sam has personified at least three of the four of characters which make up his personality.

Sam's characters appear to have different functions for him. The pilgrim is 'looking for something, going somewhere' which could be seen as a representation of his struggle to recover from PTSD, the pilgrim is pushing Sam to move forwards and make progress, perhaps looking for a new way of being. Joseph appears to be more redolent of Sam's hopefulness. Sam does not explore here what the religious significance of this figure is for him, but Joseph is a name which conjures much religious iconography, such as his role as a father or protective figure. He can also be seen as a figure of support and forgiveness after he believes Mary that she has not been unfaithful to him and that her baby has therefore been immaculately conceived. This kind of support might be what Sam needs, or wishes he had, and certainly Sam seems to depict Joseph as a representative of his ability to self-soothe, enabling him to be 'calm and rested' and take a different perspective.

In contrast to these two characters, Sam offers less description for 'me', implying that the pilgrim and Joseph represent Sam's more public face and allow the 'me' to remain hidden. This reticence is even more pronounced in Sam's reference to a darker side. This side is not mentioned in his original list of three and is left unnamed, facts which suggest that he mentions it only reluctantly, that he cannot or

does not want to explore it further. Alternatively, it could be read that this darker side and 'me' are in fact, one and the same which would explain why the darker side was not initially mentioned. Whether this is the case or not, the lack of description or facelessness of this darker side means it is unclear what it is or might represent. Instead it lurks ominously in the background.

While in some respects, Sam's account could be read as an emotionally intuitive and in depth depiction of his internal world, Sam's brief reference to 'nutter' does carry a hint that he himself might harbour worries about the implications of this conceptualisation of himself. He is adamant that these are not 'voices', but parts of himself, but this statement could also be seen to indicate that Sam is aware that voices in his head might not be considered positively.

Sam's worry is underscored by two phrases which offer very different levels of interpretation. Firstly, right at the start he talks about 'a battle in the mind'. As well as recalling his military past, this could be interpreted as a simple reflection of the fact that mood and opinion are not constant and that different aspects of a person's personality are dominant at different times depending on both internal and external circumstance. A more threatening version, however, could understand this phrase as giving credence to the idea that these characters are more independent than Sam claims, battling it out against each other rather than all being part of the wider whole that is Sam.

The second half of this phrase 'for me personally' can also be seen as ambiguous. On one level it appears that Sam is simply making it clear that this 'battle in the mind' is what it feels like for him, but that he is aware that this might not be the case for other people. A continuation of the more threatening or sinister interpretation however, might read this sentence as implying that the battle in his mind is *for* Sam, that he, or control of him, is the prize for whichever one of these four parts of him is the winner. This would make his brief reference to the darker side even more ominous.

It could be argued, however, that this is a very fanciful interpretation of Sam's awareness, and certainly Tom's version of self-awareness appears to be much more about a practical appreciation of what is possible, or reasonable to expect:

> *My aim is erm…by and large the symptom management […] because in using some of the things I've already learned erm...it doesn't stop the horror of the symptoms, but I just-I managed them in a different way, rather than just experience them until they go away – I feel that I can, to an extent, control them, minimise them* (479)

and later:

> *because I can manage some situations a bit better erm…and…its helped me retain my optimism because I generally was historically an optimist […] I can't make it go away forever but there's things I can do, and I would like to learn more and I need to practise more. And it's my hope, I think, rather than belief at this stage, my hope that I manage well enough to be able to continue. If I can continue to say I'm content, then I've got far enough. And it's not because erm…I don't see that as a compromise, I see that as being realistic given my personal circumstances* (534).

For Tom, then, self-awareness is enabled by learning about symptom management and practising these techniques. His use of technical language or jargon such as 'symptom management' and 'experiencing' symptoms suggests that this practical or theoretically based approach is a method which might work well for him in enabling his coping. This sense is reinforced by his repetition of the word 'manage' or 'managed' four times. The benefit of this system for Tom seems to be that it allows more space for his personality to come through. His description creates an image of these symptoms as an overwhelming force which has in the past been so overpowering that Tom's underlying personality or characteristics, such as his optimism, have been crushed. There is an element of Tom regaining power in the first part of this quote, he no longer has to endure the 'horror', and this makes sense in the context of his earlier quote where he explored the value of an having an equal relationship with his therapist.

Ultimately though, Tom seems to be painting a realistic picture about what is possible, rather than an idealistic picture where he conquers his symptoms; this is about enough power and control, not about total domination. Even with this, however, he is still doubtful, hoping rather than believing about what is possible. He says he is aiming for 'content', a state which seems to be compatible with his practical and realistic ambitions.

There are however, just a couple of discordant notes which appear to jar with the sense of reason and rational tone which otherwise form the basis of this quote. The first of these is Tom's use of 'horror' to describe his symptoms. This is an extremely evocative word, suggestive of suffering endured beyond what is intimated by the rest of the extract. Rather than appear an exaggeration however, this word instead seems to throw into doubt Tom's air of practiced calm. His use of 'horror' lingers far longer than anything else he says and becomes more haunting when considered in conjunction with the abrupt end of his sentence in the second section: 'my hope that I manage well enough to continue'. The more innocent interpretation of what is unsaid here is that he means he hopes he will continue to be content, as he goes on to say in the next sentence. But another interpretation is darker, with its implications and questions about what might happen if he cannot continue.

This air of darkness is echoed by Rob in the next quote, although he does appear to be moving past this:

> *when I first started doing art, the first painting I did was quite err…it was quite-it was quite dark. It was if there was a storm in-in-in the painting. Now it tends to be, if I do a winter scene, there'll be erm pinks in it and, nice lilacs and things like that, certainly not too cold because I 've had enough of erm…the dark times, and it's been-I've-I've been in that, in that area for far too long* (120).

Rob here could be understood as conceptualising the recovery from PTSD as very simple – he has had 'enough' of the dark times and has decided to move on. But the topics he used to paint could be interpreted as a literal representation of where he has been in the past, somewhere that is dark and stormy. In this context, rather than being a simple decision to move on, Rob's art might be understood as more symbolic of his hope. There is almost a sense that if he draws lighter or less cold paintings, his mood might follow. Thus, rather than the art being a reflection of Rob, it could be understood as an expression of where he wants to be, or is aiming to be. His desire to move away from the storms where he has been 'for far too long' is explicit, but his art could be seen as more symbolic of his aims or hopes, rather than a reflection of his already having achieved this.

This idea about dark and light in art being a reflection of mood in real life is echoed by Max, who reports that art serves more than one purpose for him:

> *when I'm that focused on what I'm doing I forget about what everything else is going around and, for a short time you're in a different world, a different zone. Where if you do the art therapy […] it gives you such a short time that it's quite rough and ready, but...it actually shows feelings, […] I think I can see it because art history was my thing, and you can see somebody that perhaps has used a lot of dark colours, well, you know, what is he trying to say? A bit like van Gogh as he became more ill, his-his work became darker and darker, that's what, I sometimes I see that […] I've done tunnels with lights at the end of it err...winding roads with...potholes and things like that. Umm…stairways, you know, dark side, li-light side, I've done a hand pushing away the darkness, you know, allowing the light in* (628).

Firstly, Max appears to be saying that painting for him is not just about the artistic side, but also about some level of distraction. His use of 'different world' and 'different zone' adds depth to the level of distraction, suggesting a level of profundity beyond simply thinking about something else. This is perhaps a hint that this is a form of escape, that being so disengaged with reality might provide some peace. This idea is reinforced by Max's later description of the kind of work he produces, where the light and dark are depicted side by side, co-existing within him. His reference to van Gogh, who famously struggled with mental health problems, implies that this kind of co-existence might be quite uncomfortable and this provides some context to explain the value of being able to escape.

This type of escape or distraction also appears to emerge from Max's account through his inconsistent positioning of himself in relation to artwork. He begins by talking about himself and his focus and allows that his art shows feelings. Subsequently, however, he appears to distance himself from this by positioning himself as an art critic, an outsider asking 'what is *he* trying to say' (emphasis added). His reference to van Gogh comes in the middle of this observational position and as a consequence, when he mentions van Gogh, it is not immediately clear if he is comparing the artist to himself or not.

Ultimately, however, there does seem to be a link between the two; as van Gogh's work became darker so Max's work contains this element of darkness too. Van Gogh had a history of mental health problems and as an artist and fellow sufferer, it is not hard to see how Max might have made this connection. Max then seems to have returned to owning his personal feelings within the art, and this raises questions about whether this movement could be representative of his confusion and ambivalence towards this side of himself.

There is also a worry implicit within Max's reported sense of connection with van Gogh in that, although never definitively proved, van Gogh is thought to have shot himself. In contrast to this bleak image, however, Max seems to have maintained a grasp on a more positive or hopeful outlook. This can be seen in the light that he adds to his own paintings. Although these seem to be usually in relation to the dark which also exists, this is ultimately not a picture of total despair, particularly in his reference to 'a hand pushing away the darkness, you know, allowing the light in'. There is also an element of onward movement here, tunnels, roads and stairways are all images of travel, or momentum and movement; they are not usually associated with inertia or passivity. One interpretation here is that Max does not appear to have become mired in the darkness, unable to move.

Overall this subtheme provides a growing sense that these veterans are reporting a better understanding and in depth knowledge of themselves. What appears to emerge are very individualised accounts of how this process happens, from Sam's detailed self-examination to Tom's practicality and Rob and Max's hopefulness, but they all contribute towards an impression that these men are now better able to examine and express their experiences. This creates a positive contrast with the confusion and despair that these veterans seemed to report feeling initially, as explored in the first master theme.

5.3.3 Subtheme 3:

'This is our new regiment'[6]: Being understood at Combat Stress.

This third and final subtheme explores how these veterans describe the role played by the environment fostered at Combat Stress. In the face of the strange and isolating new world identified in the first master theme, it is perhaps not a surprise that the group support provided by Combat Stress becomes so important, forming a replacement regiment as indicated by Pat in the subtheme title above. The benefits of this are seen by these veterans in a number of ways: the return to a familiar camaraderie; the safe environment it creates for difficult and challenging therapeutic work; and the normative experience provided through listening and relating to the experiences of other ex-service personnel. Tom calls this final point: *'the therapeutic value of the socialisation part of being here'* (415), a succinct summation of the significance and worth of being around people who have had similar experiences in the past, and who struggle with similar issues in the present.

Pat's quote in the title of this sub-theme is part of his wider exploration of what this environment means to him. He starts by saying:

> *this has been the best place ever for me, best place ever for me* (452)

and then in response to the subsequent question about how it makes him feel he responds:

> *brilliant, absolutely brilliant. I have me down days er-and then me good days 'cause we all sit around as soldiers and have a chat with each other and talk about things and that-that humour – what we call it black humour, 'cause we joke and laugh and whatever like that, um…gets you in that nice, calm, relaxing mood .... 'cause this is like a-like a new regiment to us. Yeah, this is our new regiment, with people interested like you are, to ask, to help us, you know? And that's the difference* (455).

[6] A regiment is traditionally a thousand men although since the 2006 reforms many of these regiments have been collapsed into much larger regiments e.g. the Royal Regiment of Scotland. In the British Army, regiments constitute the largest permanent organisational unit for a soldier and traditionally foster a strong identity based on history, traditions, recruitment and function. Mallinson (2009) argues that this regimental system has engendered the *espirit de corps* and thus the fighting spirit for which British soldiers are known.

His enthusiasm here is embodied in his repetition of the phrase 'best place ever for me' and his use of 'brilliant, absolutely brilliant'. These phrases are almost startling given the first master theme's exploration of the issues and difficulties these men are describing. There is a real sense of hope building throughout the second master theme, however, and Pat's own enthusiasm also notable because it persists in the face of his own difficulties and his acknowledged 'down days'. His good days, however, are seen here to be the result of the company of other veterans, and Pat's use of 'as soldiers' implies that it is not just the company of men with similar experiences which is helping. There is a suggestion here of an element of pretend; a return, or an imagined return, to the days when Pat was a soldier, that while in this environment, he *is* soldier again. This is emphasised by Pat's repeated use of 'we' and 'us', even 'our new regiment', indicating that he is emotionally part of a collective group again.

There is also a sense that while in this group Pat is able to be himself. He mentions 'black humour' and implies that this is a kind of humour that is unique to the Forces. He also appears to feel that while in this group he is more likely to receive help, or even interest from other people. This seems to echo some of the themes explored in the first master theme about feeling isolated and alone in the civilian world, and that civilians are not interested in hearing their stories. While at Combat Stress, however, there are people like researchers who want to hear and actively seek these men out to get their perspective.

This matches Tom's experience of this environment:

> *People who I've met a week ago here would go an extra mile for me, because I'm a veteran. Not because of what I've done, whether it was in the Army or anything like that at all, but because I am a veteran…they would go an extra mile for me […] I behave, particularly here, like I used to behave when I was in the Army. And it's very…erm…you get the dark humour erm…and it's-it's sort of like a brotherhood, family - it's as close as you'll get to family* (373).

Tom could be interpreted as saying something about identity here, or more specifically, the value of his identity as a veteran. This echoes Pat's thoughts about the increased interest in him he perceives when back in this military, or pseudo-military, environment.

Together, Tom and Pat paint a picture which suggests that this particular environment leaves them feeling valued and worthwhile. This veteran identity seems to work well for Tom here, because, like Pat, he describes slipping back into old behavioural habits from the Army, including humour. The 'dark' humour Tom mentions reflects Pat's 'black' humour and the commonalities between their experiences create an impression of this environment as allowing them to assume part of their identity, the military part, which somehow feels unwelcome in a normal civilian environment, as explored in earlier subthemes.

From Tom's final sentence it is possible to infer that it is the people within this environment who create this kind of atmosphere. Both 'brotherhood' and 'family' give an impression of a bond which is far stronger than friendship, and yet the frequency of attendance at a Combat Stress residential centre varies for each veteran. This means that each time a veteran arrives for a residential stay at a Combat Stress centre, the likelihood is that they will not have met some, if not all, of the other veterans also residing there that week. This means that relationships are built from scratch each visit, and yet Tom is describing a bond as strong and close as family, as brothers. This could be a difficult concept to comprehend for those who have never experienced a military or service lifestyle – how similar experiences, not even shared experiences, and similar pasts can bind men together so closely, and so immediately. Tom reinforces this point a minute later when he adds:

> *'we just read each other so well […] and no one else would be able to do that'* (410).

Tom's account suggests that there is something about military service that creates a shorthand of mutual understanding which is distinguishable only to those who have also served. Max describes this in greater detail below:

> *you feel safe, you feel...you don't feel vulnerable. It's like you see somebody might have an issue or feeling a bit down or something it, you know, you're there to support each other as well. Where outside, they'd rather stab you in the face wouldn't they, than help you, a lot of people. But here, you know, somebody's got an issue it's-you help them out […] 'cause we're all in it together. You know you watch each other's backs […] That's what I feel anyway, you know, I don't feel...scared when I'm in here. I don't...it's-it's like…erm...like a Shangri La away from the world you know what I mean* (521).

Max describes a reciprocal arrangement of mutual emotional support, looking after each other when down. For him, however, this support could be seen to translate into a sense of actual physical safety. 'Safe' and 'vulnerable' could refer to both emotionality and physicality, but Max's comparison is to 'outside' where his expectation is of antipathy so strong it results in physical violence. This is not anticipation of simple indifference; Max seems to be saying that the only alternative to support and help is to be attacked. This idea of physical violence is underscored by Max's later reference to watching 'each other's backs', another reference to potential physical danger.

'Watching each other's backs', along with 'we're all in it together', also engenders an atmosphere of collectiveness reminiscent of Pat and Tom's descriptions of community above. This emphasis on physical safety is perhaps not surprising given the violent history of these men, all of whom were on active service rather than in a support role. In this context, Max's relief at not being scared could be seen as understandable. This sense of fearfulness and threat of physical injury also creates a powerful juxtaposition with Max's final image of Shangri-La. Shangri-La was a fictional place first created by author James Hilton in 1933 (reprinted 2004). He describes a type of mystical and harmonious earthly paradise which is isolated from the outside world. This description of a kind of refuge mirrors the way in which Max talks about Combat Stress, with a sense of protection and lack of vulnerability that might well make it seem like a paradise. The ultimate sadness here is that Max will always eventually have to leave Combat Stress and face 'outside' again.

In the meantime, however, there is a sense that this environment can provide information, support and help which makes facing the outside world less traumatic. This is explored by Rob below:

> *there's me, five foot six, burst into tears. And when I saw some of those guys in there, and there were some big lads in there, bursting into tears, I didn't feel so bad […] I mean we always had the adage that the bigger they are, the harder they fall. But you'd think a big man wouldn't cry and-and it's only through coming here that erm…I've sort of come to accept that it is ok to-for a man to cry, because it's an emotion and we're not in control of our emotions* (366).

Max's references to physicality are echoed here, as Rob equates size or height with emotional strength rather than a more usual association with physical strength. His use of the idiomatic 'the bigger they are the harder they fall' serves to emphasise the shock or surprise he felt at seeing such men cry; their size seems to dramatically increase the impact of their tears. It also serves to emphasise a different point, namely the strength and depth of Rob's stereotypical views about men and the nature of masculinity. There is an inherent sadness to Rob's unspoken sense here that he cannot or must not show emotion, despite everything he has been through. Instead, it seems that he must keep these feelings to himself. But ultimately, however, this is a positive experience. It is what could appear to be an unrelated factor, physical size, which drives home to Rob that emotion is acceptable. He can be seen to be describing a normative experience through which he makes an important personal realisation, that he cannot expect himself to have emotional control.

While Rob clearly values the positivity of this kind of group learning or therapeutic work, however, this is not the whole Combat Stress story for him. In contrast to the experiences of safety reported above, most explicitly by Max, Rob does not feel physically safe at Combat Stress:

> *I've heard so many people say that this is a safe place, they feel safe when they come here. Actually I don't. I feel vulnerable because when I walk around here in the early hours of the morning because I can't sleep and there are security lights on out the back - well, why have they come on? Something…and I go then into a zone where I'm thinking we're-we're vulnerable here. There's a possibility of something happening here while we're here. But e-chances are…very, very slim, but I don't see that. I think that I am very vulnerable - me personally, not everybody else, just me* (185).

This is a different perspective on this environment and is marked by the contrast it creates with the experiences explored above, powerfully demonstrating the variance in personal experience that the same situation can create. Rob is outlining here a similar kind of vulnerability that Max above feels when he is outside Combat Stress, portraying an image of isolation and loneliness with the idea that he wanders alone around the building at night. There is an irony in his use of 'security lights' because it is these lights, which by their very definition should contribute towards a feeling of safety, which make Rob feel more vulnerable. They appear to set off a series of spiralling negative thoughts about the possibilities of danger which defy Rob's attempts to reason with himself by arguing that the 'chances are very slim'.

Finally, however, there is an intimation that this feeling of vulnerability comes from within Rob himself, rather than from any actual security failings of the building. His description of such an intensely personal sense of danger that does not apply to anyone else carries with it the suggestion that this is a danger that will therefore follow Rob wherever he goes. Perhaps the ultimate conclusion from this might be that he is describing a sense of having not recovered from PTSD, while feeling that those around him are doing so. Given this interpretation, it is perhaps unsurprising that there is a hint too that this danger is related to his military career. In using the word zone to describe a place in his head, Rob is possibly unconsciously evoking a military environment where 'zone' is so often used to describe a theatre of war, such as warzone or danger zone. It could be argued, therefore, that it is the sense of danger engendered by Rob's time in a real warzone that he still carries with him today.

This interpretation of Rob's experience as a very personal sense of danger means that in general, what emerges from this subtheme appears to be an overwhelming appreciation of the community or group experience of Combat Stress. Given the sense of isolation and exclusion that is explored in the first master theme, this is perhaps understandable. These veterans portray this environment as a place of safety but also of humour, it appears that this is a place where they can be themselves without concerns about the negative consequences this might create.

5.4 Summary

Overall then, the themes above provide both a direct and an indirect look at the experience of therapy in these veterans' lives. They examine the confusion and threat to these veterans' sense of self before they were able to access help, their struggle to adapt to their new civilian identity and the isolation and sense of exclusion that this creates. They describe experiencing a lack of interest from other people, including the NHS, negative experiences with therapists, and the subsequent struggle to access the necessary help. It also includes a sense of having been abandoned by the Armed Forces, that once no longer active service personnel, they are no longer of interest to their previous employers.

This lack of understanding highlights the value of the growing awareness that is also described by these veterans. In overcoming these obstacles they explore their own internal resistance to therapy, along with a move towards greater acceptance and engagement and the role of the therapist in achieving this. The benefits of therapy are considered through the greater depth of knowledge acquired about themselves, the use of therapeutic skills, and an increasing ability to express themselves. Finally, the value of being understood by other people and given normative experiences is explored in the context of the group environment of Combat Stress.

6. Discussion

This analysis offers an interpretative understanding of how these six participants have experienced therapy. This is not an exhaustive or conclusive account, simply one way of making sense of their experiences. This section will explore these phenomenological accounts in more depth, offering some suggestions to explain some of the convergences and divergences that have emerged from these participants' accounts. Some of the emergent themes are then grounded, as far as possible, within the context of the existing research. Although there is not space in this discussion to explore all the areas of interest that this analysis has raised, themes have been chosen that seem to best address the research question of how these veterans experience therapy. The implications of this for counselling psychology practice are considered and the research as a whole is considered from a reflexive point of view. Finally, the limitations of this study are discussed, and suggestions for future research are made.

6.1 Phenomenological overview of analysis

This analysis has understood these participants' accounts to offer a picture of therapy with a much wider scope than simply what happens in the therapy room. Instead, they also illuminate the experience of therapy from a more longitudinal perspective, creating the idea this experience begins some time before the therapy itself. For these veterans, this seems to be as far back as leaving the Armed Forces, an event which appears here to have been a factor in triggering the onset of problems which ultimately led to their diagnoses of PTSD. Thus, these veterans provide an account of therapy which covers the context of the experience, as well as the detail.

Overall, what emerges is a complex process marked by confusion, uncertainty and a struggle to understand, which is only gradually alleviated by a gathering of information, the growth of trust and developing understanding. Despite these similarities, however, the experiences of therapy outlined by these six participants also contain a great deal of variety. The convergences and divergences explored in the previous section are reflective of the epistemological view that there is no one truth, that individual, personal, familial, social and historical facts combine to ensure that no one experience is the same for two people (Crotty, 1998).

In many respects, the sample included in this study represents a fairly homogenous group; they are all male, aged within 11 years of each other, have had active combat service careers as non-commissioned officers and have received therapy from the same organisation. Yet despite this, their experiences are as individual as they are similar. It is only possible to speculate as to these differences rather than give conclusive answers, but there are factors which could be considered to have influenced the diversity in these accounts.

There is a marked contrast, for example, in the years of experience that these veterans have of therapy. Ralf stands out in this respect. With twenty years of experience he has the most therapy by some distance, and he is also the only participant with experience of receiving treatment for PTSD while still in the Army. This raises a question about whether there is a link between this experience and the anger which dominates his account, evidenced by his frequent swearing and scornful tone across all of his extracts. He came to his interview carrying a folder containing his service and NHS documentation, and also photos from his time in the military. These are explicit, brutal and shocking, and they are meant to be. Ralf's story paints a picture of someone who has been excluded from the therapeutic process through language and terminology, who has experienced a therapeutic environment as being akin to a prison or horror movie, and who has felt ignored and marginalised by an institution he loved, identified with, and desperately wanted to remain part of. In this context it could be considered understandable that he felt the need to offer proof of who he was, that he felt he had to shock people to get them to listen to him rather than to his symptoms.

Ralf's experience with the Army is perhaps most closely mirrored by Pat's, whose account appears to report a similar wrestling with the change in identity from military to civilian, with being let down by the military which he loved, and who also has had to overcome himself and his patterns in order to engage with therapy. Pat's twelve years in the Army were followed by eight more in the Territorial Army (TA) as a way of maintaining his contact with the institution, and this need to belong can perhaps be seen in his identification and enjoyment of the group environment at Combat Stress, an environment he has named his 'new regiment'.

Sam's account presents more contradictions. Of all these participants, he stressed the most that he would not talk about his military experience. He made it clear that he would not participate if information on his service career was required. But this is belied by what seems to be frustration and

disappointment with the lack of interest he perceives from civilians, 'they don't want to hear'. Perhaps the interest demonstrated by being asked to participate in research and having his story heard was what prompted him to give what became one of the richest and more detailed accounts of the participants' experiences of therapy. Despite having, along with Rob, the least experience of therapy (three years) Sam's speech was full of metaphors, including Jekyll and Hyde and the depiction of himself as many voices, and this is argued as indicative of the depth at which Sam is able to think about himself, his experience and his therapy.

Rob remains more of an enigma and there is a sense of loneliness that runs throughout his account. This sense of separation is underscored by the fact he twice offers a divergent opinion on a theme. He alone references his suicidal thoughts, and his sense that he had to hide his emotions. Despite this, or perhaps because of this, he also highlights the value of moments when this isolation is overcome – as in his experience with a policeman on the hard shoulder of the motorway, and in seeing other men, bigger men, cry. Ultimately, however, he remains alone. It is his divergent experience of feeling unsafe at Combat Stress which undermines an otherwise unanimous perception of security, and his final quote describing how he wanders around the building alone at night has echoes of his first extract where he was sitting in his car alone at night, reinforcing this sense of isolation.

In contrast is Max who, despite being the only participant who did not serve in the Army, does not noticeably set himself apart from the others, or strongly identify himself with the Merchant Navy. Indeed, although the majority of veterans at Combat Stress are from the Army, he too reports a feeling of comradeship and mutual protection while there, going as far as to call it a 'Shangri-La'. He also has limited therapeutic experience with three and a half years, but still speaks eloquently and in depth about the value of art therapy. He and Tom are the only veterans to have referenced their academic achievements; for Rob this is a degree in art history which helps explains what art means to him and the significance that he derives from it.

Tom, however, seems to manifest his academic achievements in a slightly different way. Like Ralf, Tom has significant therapy experience (eleven years) and his experience seems to be more consistently positive than other participants. It is possible that this academic background contributes to this; his degree was in psychology and he also has experience of working in the NHS. Perhaps this

knowledge meant that he was able to recognise what was wrong much earlier than other participants, and was therefore able to seek help appropriately much earlier too. Tom's measured tone and use of therapy language stand out from the other participants' more colloquial speech and could be interpreted as evidence of the depth of his psychological understanding of his PTSD. In framing his personal experience in these terms, however, he also creates a sense of being more removed from it. This could be understood as his way of containing his suffering in a practical and therefore manageable framework, but it also hints at an underlying pain that he cannot quite experience fully, and so has to be measured and controlled.

These are just some of the possible explanations for the divergent experiences in this study, but as above, are speculative rather than conclusive. Like the analysis, they are based on the subjective and interpretative understanding of the researcher and another researcher might have drawn entirely different conclusions. They do, however, offer a perspective on the research question of this study.

6.2 How do veterans diagnosed with PTSD experience therapy?

Perhaps the first thing to consider here is what these veterans might be telling us about how they define 'therapy'. As discussed earlier, in order to maintain this research's commitment to hearing the perspective of these participants (Smith, Flowers & Larkin, 2009), they were not given any pre-defined parameters for what this research meant by this term. Instead this space was left for the participants to fill with their own definition or perception.

Discussed above is a definition of therapy that appears to have emerged from this analysis which is both broader than what happens in the therapy room, and starts long before the therapy itself. This experience includes the process of finding therapy, the experience of rejection and confusion, and of the unknown. When the focus does turn more towards therapy itself, these veterans explore their sense of their own commitment to the work, their growing self-awareness, and the role and impact of other people. With the exception of art therapy, no specific therapeutic modality is mentioned. This is in contrast to existing research which tends to focus comparisons of the efficacy of specific treatment methods such as cognitive behavioural therapy (CBT) or eye movement desensitisation and reprocessing (e.g. Benish, Imel & Wampold, 2008; Bisson et al. 2007; NICE, 2005) rather than a more personal perspective.

In some respects this contrast might not be a surprise. As discussed in the literature review, current perspectives of PTSD have been strongly influenced by a positivist empirical position and as such produce findings that focus on objective fact rather than experience (Willig & Stainton-Rogers, 2008). This research, however, has approached therapy from a different, more subjective perspective and so the lack of applicability of one set of findings to the other is perhaps to be expected. As a subjective and interpretative account, these results cannot be offered as 'proof' for an existing theory, nor should they be. Instead, they can be considered to offer a different perspective on existing theory and research and in doing so, perhaps offer a more indirect answer to this research question.

For example, the focus that these veterans seem to place on the role of other people as part of their therapeutic experience suggests that relationships or community form an important facet of therapy for them. This can be broken down into two broad categories. Firstly, the group or community spirit of the military which these veterans report struggling to leave behind, and appear to recreate in the group work at Combat Stress. Secondly, the experience of being let down by others, of feeling misunderstood and rejected. The following sections will examine these two categories in more depth, exploring how they cast light on the experience of therapy before looking at the implications of this for counselling psychology practice.

6.2.1 The persistence of a military or group identity.

On average, these six participants left military service over 20 years ago (four in the eighties, one in 1993 and one in 2006), but the manner in which they refer to the military at times is more suggestive of a career that has only just ended. So what is it about the military that creates such a powerful group identity that it persists so long after a military career has ended?

Firstly, it should be considered that the military in terms of a career is a completely different proposition to say, becoming a lawyer or doctor. It is as much a lifestyle as a job and with it comes a relinquishing of control over many aspects of daily life, including where you live, and in some instances, what country you live in. Segal and Segal (1976) have suggested that this influence has a wider reach too, that military service can influence social attitudes such as opinion of government and foreign policy. More specifically, they found that these influences can depend on the branch of service in which you served.

A group is a difficult entity to define (Hogg & Vaughan, 2008). Cartwright and Zander (1968) classify it as 'a collection of individuals who have relations to one another that make them interdependent to some significant degree' (p. 46). For the military, the significance of their interdependence could not be greater; they depend upon each other with their lives: 'nowhere in civilian life is the social group of such major and crucial importance in the life of the individual as it is for the soldier in combat' (Manning, 1994, p.2). Janis (1968) argues that this risk to life is the reason behind the lack of self-interest in favour of the group - it is the very fact that the group faces external danger which solidifies their unity or cohesiveness. Danger means that the individual needs the group more to survive, promoting greater affiliation with the group as an extension of his or her self and subduing individuality in favour of group norms, as illustrated by Tom:

> *It's sort of like a brotherhood, family – it's as close as you'll get to family* (377).

Janis's (1968) model is based on a Freudian understanding of a group as a network of transferential reactions. The leader becomes a substitute parent and this surrogacy provides the motivation for sharing common ideals and standards with them. This can be an unconscious regressive reaction caused by separation anxiety; the individual's cohesion to the group is therefore motivated by a drive to ensure that significant figures will not leave, or 'abandon' them.

For Freud (1955) this is an illusion, a moral contract based on the idea that the head of the army, the commander-in-chief, acts as a substitute father who loves all the individuals in his group equally. Each unit forms a sub-group of this, with the captain acting as commander-in-chief and further still, with non-commissioned officers acting as commander-in-chief for their platoons. Without this illusion, Freud argues that an army would dissolve. As an example of this, Freud points to the high incidence of war neurosis in the German Army of the First World War, and argues that this was due to the hard treatment of the men by their leaders (along with a protest of an individual about the part he was forced to play in the war) which prevented these kind of substitute relationships from developing.

These understandings of the significance of the figure of the leader fit with Faris's (1976) argument about the importance of basic training. He argues that the role of drill sergeant is crucial in the process of creating a military identity because, amongst other duties, he becomes both a role model and a substitute father. His finding that 91% of trainees interviewed over an eighteen month period rated their drill sergeant positively matched Janis's (1968) over-idealisation that comes with this unconscious substitution of attachment figures. The importance that they take on means individuals can become overly sensitive to approval and disapproval from the leader. The loss of a leader, or the start of misgivings about him, can cause mass panic in the group as a whole.

In fact, there is an argument to suggest that it is the basic training undergone by all recruits that is responsible for creating the strength of the military group. Consider the following from Ralf which is explored in the previous section:

> *It's inbred in you, you've got to brutalise a serviceman to get him to do what you do, you've got to remodel him or her to go and do what they do. If you don't do that fucking how they ever going to carry your orders out, go do the job you want them to do?* (Ralf, 950)

This creates the image of a serviceman as the creation of his basic training, and there is support for this in the literature. Faris (1976) argues that the training ground provides the forum through which civilian status is shed in favour of a military identity. There are a number of features of initial training which contribute to this. These include: the disparagement of civilian status; isolation from civilian society in comparison to a total lack of privacy from other trainees; evaluation on a group rather than personal level; an emphasis on masculinity and appropriate aggression; and the creation of both physical and psychological stress. It is on the training group parade that these separate individuals become a group.

The value of this kind of training has been much discussed. Moran's 1945 work *The anatomy of courage* (2007) suggests that training promotes the voice of duty which puts the group before the individual, which creates a sense of belonging to the other men rather than to themselves, which stresses the 'voice of the herd' (p. 41) and is supported by the threat of both physical and moral consequences if ignored. This kind of automatic reaction is also highlighted by Rivers (1918) who argues that it is the comprehensive training that recruits undergo which teaches them to adapt calmly to any situation; endless practice renders the events of war so familiar that they react and

adapt automatically. He goes on to point out that the reality of wartime means that what would have been years of training is cut short, leaving men unfamiliar with much of what they face and therefore, unable to adapt.

In contrast to the extreme and potentially life threatening situations that an active serviceman might face, it might seem almost facile to suggest that new situations faced in an unfamiliar civilian environment could cause an equal amount of stress. And yet the analysis above suggests that even everyday tasks such as driving home (Rob), or getting to sleep (Max) are rife with difficulties, leading to panic and sweating. The civilian environment is unfamiliar, especially to men such as Pat who joined up aged fifteen. Pat would have been accustomed to having training to support his decisions, but he was not trained to cope with civilian life and thus, has struggled to adapt:

> *Well they train you to kill see, and defend yourself, and protect yourself and you're doing that in civvy street.* (36).

Therefore, training seems to play a crucial role both in forming the group and in teaching that group to adapt to military life. Its rigour and difficulty might contribute to the persistence of the group identity as well. Hogg and Vaughan (2008) point out that the involvement of pain in initiation rites can seem puzzling. Why join a group if it necessitates going through a severe initiation? Or if joining is unavoidable, why do they subsequently feel a sense of commitment to that group? Hogg and Vaughan use Festinger's cognitive dissonance theory to explain this, pointing out that there is a gap in reasoning behind an individual willingly putting themselves through a difficult initiation to join a group that they do not subsequently value. Thus, negative aspects of the group are downplayed and focus is awarded instead to more positive aspects, leading to a positive evaluation of the group overall. On this basis, the more extreme the initiation is the greater the subsequent commitment to the group – and military training could be considered as the toughest of initiations.

There is also an argument concerning identity and self-concept. The military gave these men an identity which is considered to be one of the most important motivating factors for joining a group (Hogg & Vaughan, 2008). It provided a definition of who they are, how they should behave and prompted a certain level of respect from others. These kinds of norms also provided guidelines for behaviour and a subsequent reduction in the anxiety caused by uncertainty. In leaving the military, in exchanging uniforms for civilian clothes, these men also lost certainty and rules that came with it.

O'Connor, Lasgaard, Spindler and Elklit (2007) highlight findings where PTSD symptomatology has been present in cases that lack an adequate criterion A stressor. They posit that this could be because some stressors pose a threat to identity, and that this 'threat to the psychological or social integrity of a person is in some cases comparable to the threat of the physical integrity' (p. 329). The veterans in this analysis describe a homecoming environment where they feel misunderstood by a large part of the population, as outlined by Sam:

> *And they think that you're a killing machine. You know, I'm not a killing machine, I'm a human being, trying to protect* (504).

This sense of being misunderstood includes those in the mental health services who might be in a position to help and mirrors Shay's (2002) argument that veterans returning home frequently feel alienated from the civilian population. This, added to the fact that these veterans are abruptly separated from their familiar group when leaving the military, could mean that military discharge and homecoming could be understood as both a psychological and a social threat to identity.

So these veterans have been through a training initiation which formed them as a military group and created a cohesiveness that lasted through years of active service. Yet now they find themselves in an unfamiliar environment, with no training, and without the support of comrades with whom they have worked for years. Is it a surprise therefore, that they find it hard to adapt? Remarque succinctly sums this up in his novel *All quiet on the western front,* 'you can't just take it all off like a pair of socks afterwards' (p. 61, 1929/1996). The cohesiveness that promotes unselfish and dangerous action in war is the result of bonds so tightly woven that they prove difficult, or even destructive to relinquish (Manning, 1994). It is no coincidence then that most of the participants interviewed here still refer to their military comrades as a brotherhood or family, or that Pat describes the pseudo-military environment at Combat Stress as his 'new regiment' (460).

The psychological theories outlined above create a theoretical basis which helps delineate the factors which make the environment at Combat Stress so positive for these men, as outlined by the final subtheme in this analysis. This is a group that they understand, an identity that is familiar and safe, comes with a shared humour, shared language, recognition of similar experiences and a cognisance of what the other might want or need.

This is in stark contrast to the civilian world which is painted with an almost alien feel, a land of unfamiliar people and unfamiliar customs, full of potential and real experiences of rejection, and as wary of them as they are of it. Given the discomfort that this seems to engender, is it any wonder that Combat Stress becomes such a safe haven or 'Shangri-La' (Max, 527)? Or that this proves to be the environment in which they can overcome their mistrust of civilians and engage with therapy?

6.2.2 Being let down by the Armed Forces

The theoretical understanding outlined above provides some grounding for the ideas that emerged from this analysis about the importance and longevity of a military identity and the role of the group environment for healing purposes. This analysis, however, did not just depict this idea that the group is solely positive, or that these veterans' experiences of therapy through other people have been uniformly beneficial. A picture also emerged of a series of negative encounters – with civilians, with therapists and other mental health professionals, but above all, with the Armed Forces.

According to Shay (1995), being let down by leadership undermines morale and contributes to the onset of PTSD. He argues that the military is a moral construction, and that the risks posed to life makes upholding this moral contract between leaders and men crucially important. Shay argues that when this trust, or the moral contract, fades or is broken it creates a 'moral injury' (p. 20), the catalyst which converts the horror, fear and grief of war into psychological injury. In short, he argues that soldiers can cope with war and the trauma of war, as long as they are not let down by those in command. This is congruent with the ideas outlined above about the nature and strength of the bond created between leaders and men (e.g. Janis, 1968). Thus, moral injury ruptures social trust which is the distinguishing factor between simple and complex PTSD (Shay, 2002).

Moran's account of his experiences in the First World War (2007) too delineates the scepticism and doubt that creeps into the minds of men when authority is shown to be fallible. His experiences in the trenches led him to the conclusion that a failure by authority creates doubt and a drop in morale based on the idea that 'a sense of injustice eats away the soldier's purpose' (p. 187). This sense of injustice can be created by many things, such as a failure to provide pilots with good equipment, or asking men to form working parties on their rest days. Ironically, the risk of breaking this contract has increased in modern warfare as improved technology has meant leaders and the men they lead

are no longer necessarily in close physical proximity. Instead, sophisticated weaponry means that fire power is often coordinated by members operating miles apart. Mistakes with map references for example, could lead to artillery fire aimed at the wrong troops (Shay, 1995).

In line with the thinking of Rivers (1918) and Moran (2007), Howorth (2000) points out that the enforced stagnation and lack of control in trenches of the First World War could have contributed to the numbers of cases of shell-shock. He argues that this lack of control could also be extended to the strict enforcement of discipline. He goes on to point out that the nature of a soldier's existence is to follow orders, to utilise the discipline drummed in by training, or as Tennyson so evocatively described in 1854, 'Their's not to make reply, / Their's not to reason why, / Their's but to do and die' (1996, p. 299). Men are at the mercy of their officers, they rely on them for fair treatment and care and attention to detail that could save lives. Ironically, Tennyson's poem is about an epic failure on the part of command. The Charge of the Light Brigade during the Crimean War's battle of Balaclava is infamous as one of the worst instances of miscommunication by leadership and led to the deaths or wounding of over two hundred men for no strategic gain.

These findings fit with research outlined in this literature review. For example, Hacker-Hughes et al. (2005) found that if conditions are right, namely that troops are well trained, morale is high and outcomes are successful, then war does not necessarily have to be harmful to mental health. Although the perspectives of men who suffer under this kind of failure are currently missing from the psychological literature and research, this is evidenced in this analysis by Ralf's fury about the treatment he received when he asked for help with his symptoms:

> *The Army knew about combat stress – it'd be quite fucking barking if they didn't allegedly – they just paid lip service to it […] Yeah so what we've got fucking servicemen with PTSD we're looking after them – they fucking weren't* (760).

There are also other forms of evidence which are congruent with the subjective perspective privileged by this research, namely other first person accounts. The following is Siegfried Sassoon, written in 1917 (1993, p. 125):

'Good morning – good morning!' the General said
When we met him last week on our way to the Line.
Now the soldiers he smiled at are most of 'em dead.
And we're cursing his staff for competent swine.
'He's a cheery old card' grunted Harry to Jack
As they slogged up to Arras with rifle and pack.
But he did for them both with his plan of attack.

Despite being awarded the MC for conspicuous gallantry, Sassoon's frustration with the Majors 'who speed glum heroes up the line to death' (1996, p. 194), and authority in general, led him to publish a declaration against what he believed was the continuation of the war for the wrong reasons. His perception was that the moral contract had been broken so badly that he threw away his medal and risked being court martialled.

Sassoon's courage here could be understood as a reflection of his frustration, and this too can be seen in the accounts of these participants. Pat's description of the Army 'booting' him out (40) and Sam's sense that 'they never did anything for me after I've left' (376) creates an image of the military as uncaring and unconcerned once their service personnel are no longer useful. This lack of concern and its potential contribution to mental health problems is illustrated by research cited above by Horn et al. (2006) which posits that the Gulf War Syndrome of 1991 could have been the result of a perception by military personnel that no one cared about them, a somatic reaction to the psychological injury of mistrust and possible fear that this perception generated.

Shay (2002) argues that it is perceptions such as these which lead to a breaking of social trust, the factor which Herman (1992) argues turns simple, and very treatable PTSD, into complex PTSD. Herman presents a case for a separate diagnostic formulation called complex PTSD (C-PTSD) for survivors of prolonged and repeated trauma, namely victims of captivity who have been under the control of the perpetrator. This does not immediately bring war veterans to mind, but when considered in the light of Shay's (1995) depiction of the front line as a form of captivity, it does hold some comparable factors. Shay points out that soldiers on the front line are inadvertently held captive between the enemy on one side, and the risk of imprisonment for desertion on the other. Thus he describes the front line as a 'narrow zone of fear and death lying between two prisons' (p. 36).

The case for C-PTSD being applicable to these men has other supporting factors too. Herman (1992) outlines the difference between PTSD and C-PTSD through a focus on somatic, dissociative and affective symptoms. These include hyper-vigilance familiar to most PTSD sufferers but also other somatic symptoms, including gastrointestinal disturbances. These have not been specifically dealt with in this analysis but several veterans described their issues with irritable bowel syndrome (IBS). Dissociative symptoms include disturbances in time, sense, memory and concentration, again, familiar from these participants, for example Rob's account:

> '*It's like if you're driving down the road, we're all taking in same sort of things, I suppose […] we are all seeing sort of different things, but I've got another thing running alongside of me and it's Northern Ireland, Northern Ireland, Northern Ireland all the time* (477).

There are similarities too in that the 'prisoner' does not or cannot express anger at the captor for fear of retribution which raises Ralf's experience of being told to leave the Army when he reported sick, a response which he interpreted as punishment. Herman (1992) goes on to say that 'the survivor carries a burden of unexpressed anger against all those who remained indifferent and failed to help. Efforts to control this rage may further exacerbate the survivor's social withdrawal and paralysis of the initiative' (p. 382). That these participants described their feelings of anger towards the military has been discussed above, what is also relevant is these veterans' perceptions of other civilians as uncaring and not wanting to understand leading to a sense of isolation:

> *Civilians […] don't understand and they don't want to hear about your stories […] They don't want to know and that's where it gets, where we get a bit offended by it* (Sam, 503).

There are also similarities in the understanding of the 'perpetrator' as the most powerful person in the victim's life, which might go some way to explaining why the military identity persists in the face of this reported perception of rejection or abandonment. There are clear limits to this analogy of the army as a perpetrator of the individual soldier's captivity, not least because this 'captivity' was voluntarily entered into and remunerated. It is also unlikely that the Armed Forces attempt to deprive their service personnel of their sense of self and their relationships and attachments to others – indeed, it is argued above that it is these very attachments which make the Armed Forces so effective. But when C-PTSD is considered in the context of the accounts that have emerged through this analysis, there are parallels.

The bigger question in this is perhaps around the extent to which the disintegration of trust in the military affects these men's capacity to trust at all, and if this is significant, what the impact of this will be on their ability to engage with and benefit from therapy. This is complicated by the fact that these men have been trained to follow orders automatically, which could be understood to mean a less developed capacity for independent thinking. They are also practised in the habit of secrecy to protect themselves from the enemy, to protect their families and friends from distressing information, and to avoid breaking the law through the violation of legislation protecting information relating to state secrets (the Official Secrets Act). A subtheme outlined here explores the difficulties in overcoming resistance in therapy. This appears to be largely achieved through the gradual building of a good relationship with their therapist, for example, Tom's description of his therapeutic relationship as a 'collaboration' (274). If these relationships become impossible to create because of the destruction of the capacity for trust, is therapy possible at all?

6.3 Implications for counselling psychology

This research posed a question about how these veterans experience therapy. Secondary considerations included what these veterans' experiences tell us about the current medical model of PTSD and overall, what the implications of these findings are for how counselling psychologists practise.

Arguably, the answer it has provided has been relatively broad or indirect. The participants appear to root their experiences of the therapy within the wider context of the rest of their lives, their experiences of their symptoms and, their perception of others. In doing so, they did not provide the kind of detailed focus that might have been expected in response to this question. This answer, however, could also be seen to illuminate instead something about the reality of therapy. It serves as a reminder that therapy is not experienced in isolation. It does not fit into neat boxes which can be compartmentalized and separated from the rest of experience, the rest of life.

In painting this picture, these findings could be understood as offering validation of some of counselling psychology's core values. Strawbridge and Woolfe (2010) identify three main areas which distinguish counselling psychology. These are: a growing awareness of the role of the therapeutic or helping relationships; a questioning stance towards the medical model of professional-client relationship and a move towards a more humanistic base; and an interest in promoting well-being, rather than focusing solely on sickness and pathology (p. 4).

This latter area is highlighted briefly below but it is the focus on the relationship which has emerged most strongly from this analysis. The findings could be understood as an illustration of the extent to which individuals operate within a network of relationships; of six subthemes, four deal explicitly with these participants' perceptions of their relationships with other people and a fifth includes the role of the therapeutic relationship in promoting engagement in therapy.

The role of relationships has been explored above in relation to the persistence of a military identity and the potential destructiveness in feeling let down by the Armed Forces, but even their experience of diagnosis, a secondary area of interest of this research, is explored within this context. Ralf, for example, outlines his fury at being given a diagnosis of PTSD, not because of the diagnosis, but because it was delivered with no explanation and no engagement with him. Additionally, although this is the only time a diagnosis is explicitly discussed, it could be understood as being referenced more implicitly through the importance these veterans appear to place on the relief of finding out what was wrong after years of struggling alone. Pat's experience of the Army telling him there was nothing wrong and Max's night-time sweating are just two examples of this. Being diagnosed with PTSD seems to have inadvertently become a catalyst for these veterans getting in touch with other people, including therapists and other veterans. In turn, this appears to have led to a greater understanding of their symptoms and of accessing the necessary help and treatment.

This perhaps does not offer as much insight into how counselling psychologists can manage this tension between medical model diagnoses such as PTSD and its own emphasis on the individual and subjective as might have been hoped. But it does at least provide further evidence that there is some value in a diagnosis for these men. This might not be congruent with counselling psychology's questioning stance towards this model, but what is important here is what works in practice, in reality rather than in theory. Milton, Craven and Coyle (2010) have pointed out that clients inevitably

are aware of psychiatric discourse, some even use it themselves which reinforces what has been found here. They find a way forward with the following understanding:

> *If we replace the representational-referential view of language associated with these systems [diagnosis] with a perspective more akin to counselling psychology's values and understandings […] the realities created by diagnostic classifications are not seen as actual states of being but as historically situated ways of talking that have constitutive effect. This allows us to accept the lived reality while challenging the conceptualisation* (p. 63).

This conceptualisation of the issue means that counselling psychologists can continue to adopt a more relational, subjective approach while not devaluing the experience of the participants, or ignoring the meaning or value that diagnosis has for them.

In terms of lessons learned regarding treatment then, this research does offer support for counselling psychology's relational framework. The strength of the bond between military groups and impact of the loss of this has been explored in depth in this section and there is a lesson here about the importance of trust and the destructive potential when it is lost. The focus of these men on their negative experience with others gives a message that the experience of receiving help is coloured by their experience of being let down by the Armed Forces.

Therapy then could be seen to have a role to play in recreating these bonds and re-establishing trust. Combat Stress's residential organisation appears to provide some of this already, and these accounts also provide support for the significance and value of the therapeutic relationship. There is an argument too for the kind of group therapy advocated by Kingsley (2007) where the group is understood to recreate the *esprit de corps* of regimental life. Being around other soldiers counteracts feelings of isolation, facilitates trust and communalises trauma, all attributes which Shay (2002) too highlights as crucial to healing.

Ultimately, the variety of experience encapsulated even by just these six participants supports Elhai, Frueh, Davis, Jacobs and Hamner's (2003) argument that the variety in cause and effect of combat-related PTSD means that treatment needs to be flexible enough to meet individual needs rather than adopting a one-size fits all approach. Counselling psychology maintains this flexibility through its

commitment to fitting the therapy to the individual's needs rather than the other way round and thus, on the basis of the experiences explored here, could be considered to have much to offer these men therapeutically.

6.4 Reflexivity

IPA proved to be a good choice, both for this research and for me personally. It provided a bridge between academic research and a subjective approach to practice that was commensurate with the values of counselling psychology, (DCoP, 2005). It produced an answer to the research question posed by this study but was flexible enough to allow this answer to encompass a much wider range of experiences than expected.

On a personal level, despite knowing what to expect from IPA analysis on a theoretical basis, in practice the depth of engagement with these participants' accounts still felt like a surprise, and it was one I found myself enjoying more than I anticipated. Close text analysis like this has echoes for me of previous literature studies, but here the experience was much more personal. This was not Shakespeare writing hundreds of years ago, I was there when these accounts were created. More than that, I helped create them and their analysis is a product of my best understanding of what these men wanted to say. This brought the idea of the double hermeneutic (Smith, Flowers & Larkin, 2009) to life, because while the idea that I could remove myself from this process had seemed impossible in theory, the practice of analysis proved this beyond doubt.

Having carried out the interviews and transcribed them, I had a perception that I already knew what was included. But as analysis continued from individual cases, across participants and into writing up, I was continually discovering new things, or finding a new way of looking at something. That this method was flexible enough to incorporate some of these changing meanings came to be really important to me, and it felt like an echo of previous lessons learnt about the difference between theory and practice in the therapy room. Counselling psychology is a discipline firmly based in evidence, research and theory, and yet it also demands the ability from the therapist that they be able to adapt to each client as an individual; to fit the theory to the client rather than the other way round (Milton, Craven & Coyle, 2010; Rafalin, 2010).

In some respects, the absence of other qualitative research on this topic made this process simpler, there was little temptation to 'see' in these accounts ideas that had been seen already, simply because if these accounts exist, they have not been made public. Instead, I found myself consulting more and more with expert accounts based on personal experience in the field, writers such as Shay who have worked with people who have lived these experiences, and Moran and Sassoon who have lived them themselves.

This made these results harder to fit into a pre-existing framework and caused no little anxiety for a while. Ultimately, however, I came to realise that in embracing the subjective, the individual and the absence of fact or hard truth, that this is what I should have expected, and that this is how new ideas emerge. What I have learned about IPA then is that it is a research methodology that embraces the variety and freshness of real life. Without this kind of approach I think something about the humanness of these men's accounts would have been lost.

Another factor to consider is the potential influence that I had. In the same way that as a therapist I try to take into account the impact I have, the impact of my gender, my age, my demographics in general on the client, this is also something to consider here. I cannot know on any definitive basis what difference it might have made had I been male, or older, or ex-military. A couple of veterans commented that they would never have spoken to me had I not been approved by Combat Stress, that this approval meant I could be trusted. A couple also mentioned that they would not have spoken to me had I been male. The implication behind this seemed to be that as a woman I was easier to trust and less threatening. On the negative side of this, I was conscious occasionally of some of these men tempering their accounts, or at least their swearing to make it more 'female-appropriate'. Ralf was the obvious exception to this and as a result he gave a vivid and detailed account. I wondered at times what might have been edited out of other accounts for my benefit, but I can never know the answer to this. On the whole, and in the spirit and philosophy of this research, I suspect that no researcher is a perfect demographic for a piece of work, simply because perfect will be different for everyone.

In therapeutic terms, I thought I had a pretty well-rounded perspective. I have been the therapist and I have been the client. But research such as this affords a third perspective, a kind of meta-narrative on therapy viewed at a greater distance. This is still subjective and still individual, but the distance brings home that therapy is more than theory and skill in the therapeutic room. I knew this; I had experienced this for myself and knew it to be true, but somehow the experience of research has made it just a little clearer.

I worried at the outset of this research that turning my longstanding interest into academic endeavour would somehow drain the joy or interest for me. Instead, I found that I could engage with it on a completely new level and one from where I could be even the smallest part of the experience. I have also learnt a wealth of new information. The concept of a 'soldier' or a 'sailor' has been brought to life; these are now real people who I have met rather than abstract concepts. They are not heroes, although they are definitely heroic, and they are not 'killing machines' to use Sam's phrase. They are men who have done extraordinary and unusual jobs and who are now suffering as a result.

This is not to say that the process of completing this research has been nothing but interest, engagement, learning and progress. I have been exhausted, fed up, ready to give up and walk away. I have got stuck, got angry, got tearful and lost my way more times than I can count. I have neglected my friends, my family; I have probably neglected myself. Despite this, however, I would still say that it was worth it. If only because far from having lost my interest, I now want to know more.

6.5 Limitations and suggestions for future research

In some respects, this study could be considered to be a hybrid of two methodologies. It is not quantitative by any definition, but in looking for convergences and divergences in six people's experiences it might be deemed to contain a remnant of a quantitative attitude. This study did not aim to prove anything or confirm a 'truth' which raises questions about why six participants are considered better than one. In including six, it is possible that some of the depth that could be found in just one perspective was lost; certainly some promising themes which did not fit into the wider analysis were left out for reasons of space.

Not all of these accounts would have stood up to the depth which a single case study would have needed, but a couple might have. In the end though, the decision was that this was the compromise necessary in order to give six people a voice, rather than just one. This is an epistemological issue and a decision on whether it should be counted as a limitation will depend on the personal epistemological viewpoint of the reader. In contrast, a different author might consider that one of the limitations of this study was the small number of participants, and that a larger sample would have meant a greater ability to generalise.

Other limitations might also be considered to be dependent on an individual's epistemological position. For example, this research was carried out through one charity. It is possible that the accounts therefore, have been influenced by the ethos or philosophy of this charity and a greater variety of contexts might have produced a more mixed sample. On a similar basis, these interviews were all carried out within a relatively short space of time, meaning that there might also be a cohort influence. Interviewing non-residents or residents over a longer period of time would have eliminated this possibility.

The same viewpoint which means these limitations are subjective, however, also means that the conclusions this research has drawn regarding its applicability to counselling psychology could be considered limited. Should counselling psychologists make adjustments to their practice on the basis of the experiences of six men? Perhaps this is a matter of personal choice, and certainly, as outlined above much of what appears to have emerged from these accounts serves to reinforce rather than challenge values that counselling psychology already holds as central to its identity, such as the importance of hearing the individual (Orlans & Van Scoyoc, 2009).

What is universal is the fact that these participants, with the exception of Ralf, all left the Armed Forces at least nineteen years ago. This does not detract from the validity of their accounts, but it might be worth considering how their experiences of the military's lack of concern might be different in today's climate. Even the briefest of internet searches now reveals a wealth of Ministry of Defence and NHS policy designed to take care of the mental health concerns and problems of ex-service personnel. It is possible that this was the case when these veterans were discharged and that the experience of these veterans is not reflective of the policies of the time. It would, however, be interesting to interview veterans who have left the Armed Forces more recently to see if this does influence their perception of how they are treated.

This is just one of a wealth of possible areas for further research. The emergence here of an impression of therapy experience as beginning long before the therapy itself raises questions about why these veterans pre-date this experience. It would be interesting to break down these findings and carry out research which focuses in greater detail on the experience of accessing therapy, a process which these findings suggest is difficult and confusing. Further information on this might help psychologists refine how they psycho-educate about mental health issues and treatment and this would enable counselling psychologists to maintain and further their interest in well-being or preventative health care (Strawbridge and Woolfe, 2010).

In some respects it feels as if steps have been skipped and the first question asked by research should have addressed the experience of their military service as a whole, followed by the experience of being discharged, which together might have shed light on why this is so traumatic. This research has speculated about the nature and strength of a group identity, about its persistence long after the experience itself is over, but it would be helpful to ask these questions directly. How could the Armed Forces have done better for these men? How can therapists, military or civilian better address the issues they face?

In reality then, this study might be understood to raise more questions than it answers. Perhaps that is the point of qualitative research, to lift the lid on experience so that it can be explored and examined for the lessons it might contain. But even this creates questions – is it possible to learn from another's experience? Pat Barker's *Regeneration* trilogy deals with some of the issues highlighted by this study through fictionalising the work of First World War psychiatrist William Rivers. The trilogy ends with *The Ghost Road* in which Rivers reflects on his role as a psychiatrist and wonders whether one patient has been too much at the forefront of his mind when listening to another:

> *At best, on such occasions, one became a conduit whereby one man's hard-won experience of self-healing was made available to another. At worst, one no longer listened attentively enough to the individual voice. There was a real danger, he thought, that in the end the stories would become one story, the voices blend into a single cry of pain' (p. 229).*

This is something close to the heart of the epistemology of this research and which affects the practice of counselling psychology – how to keep hold of the individual amongst the many, and amongst the wealth of theory available. There seems to be a line between the individual and the universal, between theory and practice or science and practitioner which needs to be constantly re-negotiated. In practice, this kind of negotiation is messy and involves mistakes, a reality which is mirrored by the negative experiences experienced by these participants and explored here. But these veterans have also been understood as making a point about wanting to be heard, about how being heard making them feel connected to others, to relationships and community, and ultimately this feels hopeful. There does not seem to be any reason why counselling psychology cannot continue to try to balance the individual with the universal and in doing so, transfer learning from one side to the other, and back again.

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8. Appendices[7]

8.1 Ex-Services Mental Welfare Society (Combat Stress) ethics form

8.2 Criminal Records Check certificate

8.3 Ethical permission from the Ex-Services Mental Welfare Society (Combat Stress)

8.4 Recruitment poster

8.5 Interview schedule

8.6 Participant briefing form

8.7 Consent form

8.8 Demographics form

8.9 Participant debriefing form

8.10 Roehampton University ethics application Form

8.11 Risk assessment form

8.12 Ethical approval from Roehampton University ethics committee

8.13 Example of individual case transcription analysis – Tom

8.14 Example of individual case thematic analysis – Tom

[7] In order to ensure the confidentiality of the location of the interviews carried out for this research, some of these appendices have been amended or contain small omissions. This is only where necessary for confidentiality purposes; at no point has the meaning been changed or the content altered outside of this purpose.